## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O 9 Certificate of Death Reg. No. 02501 1 - For State Registrar Physician /Medical Examiner

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercitivat Invat Leo collined at once.

Baltimore, Maryland 21215-0036

**Funeral** Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  1. 2. 5. 5. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6.												
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	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bir	Yrs. Month:		Hours	Min.	8. Date of Birth (Month, Day, Yea		Coun		r Foreign	
	218-78-3377 Usual Residence of Decedent		42					MARCH 16,	1966	MARY	LAND		
	10a. State 10b. County		10c. City, Town	n or Location						10	0d. Inside Cit	y Limits	
Þ	MD BALT	IMORE		DATO	IMORI	ē					1 □Yes	2 <b>X</b> No	
irec	10e. Street and Number	IMORE			ip Code			10g. Citizen of What Country?					
N D	6531 SAINT HEL	ENA AVE		·	2122	22		,,	.S.A.				
ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of H	ispanic Ori	igin? (Spe	ecify Yes or No-	14. Rac	e - Americ			
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mpl	Elementary/Secondary (0-12)	College (1-4or 5	i+)	`life. DO NOT		d)							
MD BALTIMORE    10e. Street and Number   10f. Zip Code   10g. Citizen of What Country?													
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	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3040 JAMES RUN RD. ABERDEEN, MÄRYLAND 21001												
	20a, Method of Disposition	TATHER		f Disposition (N ry, crematory or						City or To		·	
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	4 ☐ Domation 5 ☐ Other (S	//:	Darii	ngton C		ss of Facilit		-2009 DAR	TTING.I	CON, I	MARYLAI	MD	
	A ALLA	1		Willi	am C.	Broy	vn Co	mm. Funer	al Ho	ome-Ha	arford.	P.A.	
	William C. Brown Comm. Funeral Home-Harford P.A. 321 S. Philadelphia Blvd. Aberdeen, MD 21001  2. Frtt. Enter the disease, fr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate the property of the pro												
	snock, or hear failure. It only one cause on each line.  Onset and Death  Onset and Death												
	disease or condition resulting in death)  a.   ACUTE PANCREATITIS  Due to (or as a consequence of):												
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):												
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cian/Medical Examiner	IF FCMALC.												
an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2  Fetal death	3 ☐ Ectopic	pregnanc	v				te of delive	,		
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		t time of death		specify) _				IVIC	onth	Day Y	ear	
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Be	25. Was case referred to medical examiner?				- 1011		of Death	(Check only one)					
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ion	27. Manner of Death 1 → atural 5 □ Pendin			Time of njury M	28c. Inju	k?		28d. Describe how in	jury occur	red			
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Medical Certification: To	29a. Certifier 1 Certifyir	ng Physician: To the best	of my knowledge	e, death occurre	ed at the ti	me, date a	nd place	and due to the cause	e(s) and m	anner as s	tated.		
dica		Examiner: On the basis of and manner st	f examination ar										
Me	29b. Signature and title of certifie			2	9c. Licens	e number		29d. I	Date signe	d (Month,	Day, Year)		
	D. 14	David			REC	-000	Ś	JAI	VUAP	V 20	200	da.	
	30. Name and address of person	who completed cause of a	eath (Item 23a)	(Type Print)	,~~5	-000	J	14.11		1 28	, 200	1	
	0.	TBRADY MD	4940 E.	457 F & N	AVE	NUE	BAI	TIMORE,	MID	212	24		
te	31. Date-filed (Month, Day, Year)		ar's Signature	11 1	HAL	ME		)	IVV	0 10			
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend #5, per FH g888 2/4/99 Certificate of Death

Reg. No. 02502 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Linda Ann Christian 2009 4:55a January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Hours Months Days 62 214-48-1943 May 29 1946 TNUsual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Carroll Sykesville 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 Central Avenue 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 9 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Carroll Co. Public Elementary/Secondary (0-12) 12 College (1-4or 5+) Schools cafeteria worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Worley Davidson Josephine Moore ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George H. Christian (spouse) 906 Central Ave., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sharon Baptist Cem. 1-31-09 West Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licerisee 22. Name and Address of Facility Haight Funeral Home & Chapel tal 764 P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Minutes urmonary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or day, if a class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ¥es 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide

Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760,

attending physician for use as the buria this within 24 hours after use...

To the Funeral Director: After this

P

Certification:

Medical

State

Registrar

4 ☐ Homicide

29a. Certifier

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at angles.

**Physician** 

/Medical

N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

29c. License number

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2973 Marchester Rd Manchester MOZILOZ Hen P Sun 31. Date filed (Month, Day, Year)

🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

FEB02

29b. Signature and title of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02503 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 12:00A M 2009 23 Bernard Eugene Carter Jan. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOSEPH Richey Hospice N/ABaltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7 Maryland 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours **1**√2 M 2 □ F 1957 219-78-4648 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1XIYes 2 □ No N/aBaltimore Maryland 10e Street and Number 2430 Liberty Heights Avenue 10g. Citizen of What Country? 10f. Zip Code USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Never Married 2 Married Specify: Black 1 ☐ Yes 21⁄2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Under Armour 10th grade Stock Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Jones John Carter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 21220 19a. Informant's Name/Relationship (Type. Print) Tieria Q. Carter/Daughter 9823 Charbank Lane Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest VEt. 2/2/09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Eugeral Service Licensee |5240 Reisterstown Rd Baltimore, Md 21215 aris Part Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small conce months Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death
9 ☐ Unknown Month Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at

**Physician** 

/Medical

Examiner

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Hospital or Attending

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Physician/Medical

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Certification: To

Medical

Bernard

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

1 Yes 2 No 3 Probably 4 Unknown

24a Was an autopsy performed? 1 □ Yes 2 □ No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death

2 Accident

3 Suicide

4 ☐ Homicide

1 Natural

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

D51788 (MD)

29d. Date signed (Month, Day, Year) -23.09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

620 Boulton Street Bel Air MO 21014 MD lim 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Georgia Clark :30 PM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altima N/AIf Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 224-56-3224 1 ☐ M 2 😾 F 96 Director 5 1912 N. Dct Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 Yes 2 No Director Maryland N/ABaltimore 10f. Zip Code 21213 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be r Apt. Street USA 1300 E. Lanvale Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Bace - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.Black 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home d 2 should be filed with and Mental Hygier 7 is marked other the 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Bud Powell Lillie ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2401 Westwood Avenue Baltimore, Maryland 21215 lace of Disposition (Name of Date 20c. Location - City or Town, State Annie M. Smith/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt • Zion Cemetery 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/09 Lansdowne, Maryland 22. Name and Address of FacilitChatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, Md21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Myocardial Physician /Medical Due to (or as a consequence of): **Examiner** oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Examiner Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an certificate has autopsy performed? res 2 No 1∐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, P.O. Records, **Division or Vital** To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Baltimore, Maryland 21215-0036

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d State (Check only one)

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29b. Signature and title of certifier

AWAN

Registrar

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and manner stated.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D006586

29d. Date signed (Month, Day, Year)

Baltimore MO 21227

amend 720b Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 02505 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 00:15 **Physician** /Medical 4b. City, Town, or Location of Death County of Death (If not institution, give street and number) Examiner WID timore SAUTIMORE Under 1 Year | If Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours MXDMM 2□ F 219-38-3167 N.C. 65 2-6-1943 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10h County 10c. City. Town or Location 23a or 28a-f show arment of Health and Mental Hygiene.
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injury or other traumatic event, the Mudical Extrainer must be notified at 1√Yes 2 No Director MD Baltimore N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4918 Challeden Road Apt B 2 21207 U S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2XOXNo Specify Specify: Black þ 3 ☐ Widowed 4 💆 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Puber Lee Cox ပ Georgia Frances Turnage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Georgia F. Cox-Mother 1715 Walker Road Freeland, Md 21053 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cem 1-31-2009 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 21202 MDane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final **Physician** Cancus MA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner resulting in death) Last Due to (or as a consequence of): Box 68760 Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy signed by the atte Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 □ Ýes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) parent Other: 4 Nursing Home 5 Residence Other (Specify) 1 Yes a No Hospital: nospire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Manner of Death 28d. Describe how injury occurred After t Hospital or Attending Natural 2 Accident 5 Pending nours after death. 1 ☐ Yes 2 No investigation 6 □ Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

FEB 0 2 2009 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 690

6426

DVD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. N2 0 0 9

			For State Registrar	ate of Maryland		nt of Health and I te of Death	Mental Hygien	711114	02506
н	Physicia	an	1. Decedent's Name (First, Middle, Last)	L			2. Date of Death Month D	Year 200	3. Time of Death
,	/Medic	al	Mattie Clar  4a. Fecility Name (If not institution, give stree		4b. City	, Town, or Location of Death	-	c. County of Deal	
,	Examin	er	Keswick Nurs	11	-1 -	Baltimor		NI	A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Unde	r 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Bin	thplace (State or Foreign
	Director		214-20-9191 1LIM Usual Residence of Decedent	92	Yrs.		Sept 5, 19	914 VI	rginia
	yland		10a. State 10b. County	10c. City, T	fown or Location				10d. Inside City Limits
	89-fel	Director	MD NIA		altimo				1 Pes 2 No
	with th	Dire	10e. Street and Number	alla Ova	10f. Zi	21217	10g. 0	Citizen of What Co	
	death with the Maryland rme 23a or 28a-f ehow r must be collified at	Funeral	11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was Dece	ident of Hispanic Origin? (S ocify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ame	encan Indian,
	or ite		1 Never Married 2 Married	Armed Forces? ☐Yes 2☐Mo fYes, Give	If Yes, spe		o Hican, etc.)	Black, Whit	lack
2-003p	hours after turel', or ite	d by	3 ☐ Widowed 4 ☐ Divorced	/ear or Dates:	16a. Decedent's Usu	32	166	Kind of Business	
<u> </u>	within 72 ane. then "nat	piete	15. Decedent's Education (Specify only highest grade control (Spec	mpleted)	(Give kind of will life. DO NOT i	ork done during most of wor use retired)	rking	Mind of Business	muustry
7 7	d with giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Itom	emaker		Dome	stic
land	id be filed within 72 hours after death with the Marylar death with the Marylar then death them "naturel", or fleme 23a or 28a-f show the death then "naturel", or fleme 23a or 28a-f show the event, the Marylar Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle, Maide		
$\frac{8}{5}$	2 should be and Mental ie marked reumatic ev	ဥ	19a. Informant's Name/Relationship (Type,	Son	19h Mailing Addres	s (Street and Number or Ru	1 001	or Town State	Zio Code)
	and 2 sealth an m 27 io i		. ( ! !	son 1	949 W.	Lafavette	Ave. Ba	Ho. MI	21217
e,	es 1 a of Heg		20a. Method of Disposition  1 Durial 2 □ Cremation 3 □ Remo	cem	e of Disposition (Na etery, crematory or		1	Location - City or	Town, State
altimore,	Pages ment of tent: If it lury or o		4 □Donation 5 □ Other (Specify)	Lou	don Ra	rk 211	+100 R	altimo	
n D	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic events.		21. Signature of uneral Service Licensee	Luch		1 1	. A .	reval	MD 21207
			23a. Part1. Enter the disease, or complication	ons that caused the death.	Do not enter the mo		or respiratory arrest,	Balto	Approximate
	Physician		shock, or heart failure. List only one ca	A	Descri	1.7.10			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequen	DEMER	01/6			unknown
	Examiner	٠	Sequentially list conditions, b	Due to (or as a consequen	and of):				
(2)	nsit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequen	100 01).				
2	execu en and rial-tra	Examin	that initiated events c resulting in death) Last	Due to (or as a consequen	nce of):				
8/60,	cate be executed physicien and the burial-transit	dicai	d						
		/Mec	IF FEMALE: 23c.	f yes, outcome of pregnancy	v			23d. Date of de	livery
ROX	death certifi e ettending   ad for use as	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel de 4 ☐ Pregnant at time of deat	eath 3 Ectopic p			Month	Day Year
л О	tt the c by the tached	hys	9 Unknown	9 Unknown					
	The law requires that the de ite has been signed by the c page 2 should be detached	P	Part II. Other significant conditions contrib	uting to death but not resulting	ng in the underlying	cause grven in Part I.	23e. Did tobacco		o the cause of death?
oro:	requi	Completed					24a. Was an		
Vital Records,		idmo					autopsy performed	death?	utopsy findings available completion of cause of
a		0	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ☑ N ath (Check only one)	No 1 Yes	5 2□ No
<u> </u>	hysici nis cer i direc	To B	examiner? 1 Yes 2 No	ital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3□ D	OA Other: 4 Nursing H	lome 5 ☐ Residence	6 □Other (Spe	ecify)
0	ing Pl		1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how in	jury occurred	
Division of	death death ctor: / y the f	licat	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home	e, farm, street, facto	1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or R	ural Route Number.
2	el or setter	Certification:	4 Homicide determined	building, etc. (Specify)	-,	,,,	City or Town, Sta	ate)	
	To the Hospital or Attending Physicien: To the Funatel Director: After this certifica Completely filled in by the funeral director;	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	edge, death occurre n and/or investigatio	d at the time, date and place n, in my opinion, death occu	e, and due to the cause urred at the time, date a	(s) and manner a	s stated. e to the cause(s)
	o the	Med	29b. Signature and title of certifier	and manner stated.	29	ec. License number	29d. [	Date signed (Mon	th, Day, Year)
}	⊢ <b>≯</b> ⊢ δ		1 5/5	MD		D0059054		1/29/0	9
	6		30. Name and address of person who compl		3a) (Type, Print)			1 -4	
			31. Date filed (Month, Day, Year)			40 TH STreet	BALT	40 21	211
Ste	Sta	ite rar	31. Date filed (Month, Day, Year)	32 Registrar's Signatur		-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 735 January Maryjane Collison 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Baltimore Baltimore If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Director 219-30-6238 June 3,1936 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, "the Medical Examinar must be refitted an once. 10a. State 10h. County 10c. City, Town or Location 10d Inside City Limits **Funeral Director** 1 □Yes 2 No MD Baltimore Boring 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4525 Piney Grove Road 21020 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 📉 No ģ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Breitschwerdt Gladys Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Collison 4525 Piney Grove Road, Boring, Husband MD20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation — 5 ☐ Other (Specify) Glen Haven Mem. Park 1/30/09 Glen Burnie, MD of Fuheral Service Licensee 22. Name and Address of Facility -11824 Reisterstown Road J. Wayne Osterling Eline Funeral Home Reisterstown, MD 23a. rart1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fails e. List only one cause on each line. Approximate Interval Between Qnset and Death Imme to Cause (Final disease or Immelition resulting in death) **Physician** Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 DNo 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2/Z/No 11 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760; within 24 hours after deatl To the Funeral Director;

burial-tran

physician the

ed by the attending p detached for use as i

cate has been signed page 2 should be det

funeral director,

After t

Baltimore, Maryland 21215-0036

Mary Lano

Collison,

SAN

J

completely

Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Singi 31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

28th, 2004 January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	•	rtificate of		ientai Hy	Reg. No 200	9 02508
	Physicia /Medic		Decedent's Name (First, Middle,  Held	Last)	ski			2. Date of Dea Month		ar 3. Time of Death
	Examin		4a. Facility Name (If not institution,  Joseph Richie Ho	give street and number)		4b. City, Town, c	r Location of Death		4c. County of E	Death
	Funeral Director		217-40-0267	. D	rs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 1	th ay, Year) 9. 1,1944 Ma	Birthplace (State or Foreign Country) ryland
	yland sow		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	ne Mary 8a-f sh	Director	Maryland Baltim	ore	Dune	dalk	· · ·			1 □Yes 2 🛣 No
	3a or 2		10e. Street and Number 3471 Dunhaven Ro	ad		10f. Zip Code	21222		10g. Citizen of Wha USA	: Country?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cub 1 □ Yes 2 [X]No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		American Indian, Inite, etc. White
15-0	n 72 ho n"natul	oletec	15. Decedent's (Specify only highest	grade completed)	16a. Deced	dent's Usual Occup kind of work done OO NOT use retire	oation during most of workir d)	ng	16b. Kind of Busine	ess/Industry
212	ed withii /giene. er than t, the M	Completed	12 years	College (1-4or 5+)	1	ousewife			Own Hom	ie
land	d be file ental H ked oth Ic even	To Be	17. Father's Name (First, Middle, La James Kaneicki	st)			18. Mother's Name Gloria C		Maiden Surname)	
, Maryland 21215-0036	1 and 2 should be filed Health and Mental Hygi em 27 Is marked other ther traumatic event,		19a. Informant's Name/Relationship Edward B. Scheve	, ,,	I	-	and Number or Rura Road, Dun			
Baltimore,	permit. Pages 1 a Department of He Important: If item any Injury or othe		20a. Method of Disposition 1	Removal from State HO	Place of Dispo cemetery, cren oly Rosa	sition (Name of natory or other plac ry Cemete	February 3, 2	åry 009	20c. Location - City Dundalk,	
Balt	permit. Depart Import any Inj		21. Signature of Fundral Service Lie	censee Connell	ly 3	Name and Address Onnelly I 110 Solle	ss of Facility Funeral Ho ers Point	me Of I Road, I	Dundalk,P. Dundalk,Mc	A. 21222
	Physician /Medical		23a. Part 1. Enter the diseas 1, of conshock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	_a(V	ong can	er the mode of dyi	ng, such as cardiac o			Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a conso						
J	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
8: 25 68760,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conse	equence of):					
99 S		Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of Month	delivery Day Year
1/24/ ords, P.C	w requires that s been signed b should be deta	þ	Part II. Other significant condition	s contributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	10	obacco use contribut ∕es 2  No 3  □	e to the cause of death?  Probably 4 Unknown
ewsKi of Vital Records	sician: The law re certificate has be irector, page 2 sho	Completed						24a. Was a autop perfor 1 ∐Yes	rmed/?   deat	a autopsy findings available to completion of cause of h? Yes 2 □ No
Vital Vital	/sician s certif lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ Ño	Hospital: 1 ☐ Inpatient 2	□ FR/Outpatien	t 3 DOA Oth	26. Place of Death ler: 4 ☐ Nursing Hon			Sansita Harrica
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day, Year)		28c. Injui Wor	ry at 2		now injury occurred	Specify) HOSP(C)
En Dy Division	tal or Atters after de al Directo	Certific	3 Suicide 6 Could not determine	building, etc. (Spe				City or Tow	vn, State)	r Rural Route Number,
Helen	e Hospital 24 hours a e Funeral detely filled	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my k aminer: On the basis of exami and manner stated.	nowledge, death ination and/or in	n occurred at the ti vestigation, in my o	me, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	^		29c. Licens	e number		29d. Date signed (M	onth, Day, Year)
	U		30. Name and address of person wh	o completed cause of death (It	tem 23a) (Tyne 1	Print)	10064267		1-30	-09
	H		Dr. K	audit Consuls-	Brown	827	Linden Av	. Balt	unal, Mo.	21201
	Sta Registra		31. Date filed (Mpna, Pay (Year) 2	109 Registrar's Sig	H. And	chad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorsey **Physician** 02:51 AM Eunice Tanuara 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-32-5547 Months Days 71 Director 9,1937 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatht and Mental Hygiene. Int: If them 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho dical Examiner must be notified at Baltimore MD N/ADirector 1 XYes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1211 E. Federal St. 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 2 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4 or 5+) 9th Grade Maryland Clubhouse Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Smith James Dorsey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 2837 Mayfield Road Baltimore, MD 21213 Patricia Jenkins/ 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ott Zion Cemetery 1/24/09 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulseless **Physician** 12 hours /Medical Due to (or as a consequence of) Examiner Stage years Same rively list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and defor use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 TYes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 2 🗌 No 1 Yes or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 24 hours after death. Funeral Director; A 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ģ 4 Homicide Cify or Town, State) filled in To the Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Stuby, Medical Doctor

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Stembers, Johns Hopkins

Registrar's Signature

RES-000

Hospital

January 18, 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 5,26,290 per in dr., 2888,02/02/09dinb Reg. No. i 1 - For State Registrar Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1900 M **Physician** 2009 Pauline 21 4a. Facility Name (if not institution, give street and number) anuary /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 0 t more HOSPIJ If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 587-90-4116 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1□M 2**√**F Days Months Min Yrs July 22 1955 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Des 2 No Baltimore 10f. Zip Code Director MD 10g. Citizen of What Country? 10e. Street and Number Heights Ave f

12 Was Decedent Ever in U.S.
Armed Forces? 21215 42U Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 NO 1 ☐ Yes 2 No Specify: Specify: ģ Whi 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife nome 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Therio Jennette ၉ Eduaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barr Heights Ave. Apt. Do Bilto, MD 21815 7018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11-31-09 o Crematory 11
22. Name and Address acility Baltimore, MD 4 Donation 5 Dother (Specify) 1etro 21. Signature Ine I Service Lice 23a. Part T. Epier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediat Cause (Final disease or condition PA18434 Approximate Interval Between Onset and Death **Physician** Acute Myocardial disease or condition resulting in death) /Medical Due to (or as a correquence of): Examiner Atheroscleretic Soque itially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): P.Ó. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Day Month Year ate has been signed by the atte page 2 should be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No Chronic 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 🖪 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide e Funeral I Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only To the 1 within 2 To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 30, 2009 1445931 and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue Surfezas Baltimoro, MD 2835 Usburah Burton 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2 2009

DHMH 17 Rev 1/2001

Registrar

		1 - State of Maryland / Dep	artment of Health and Nertificate of Death	ental Hygier Reg. ۱	7007 0751
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Carolyn Wilhelmina Doyle		Feb 1	3. Time of Death 2009 11:22 P M
Exami	ner	4a. Facility Name (If not institution, give street and number)  Carroll Hospice Dove House  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death  Westminster  of If Under 1 Year   If Under 24 Hrs.		4c. County of Death  Carroll  B. Birthplace / State or Foreign
Funeral Director		212-26-2208 1 M 2 F 80 Yrs.	Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country) 928 MARYLAND
vith the Maryland or 28a-f show	Director	10a. State         10b. County         10c. City, Town or L           MD         CARROLL         WESTMI			10d. Inside City Limits 1 ∐Yes 2X️INò
h with th 23a or 26 st be no		10e. Street and Number 416 POOLE RD, APT. B4	10f. Zip Code 21157		Citizen of What Country?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Thygiene "natural", or items 23a or 28a-f show put, the Medical Even in writes the medical Even in writes the medical Even in writes and the second	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036 d within 72 hours aft giene. er than "natural", or the Middell Even.	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ring	Kind of Business/Industry
land 21 Id be filed withental Hygien ked other the	To Be Cor	9 17. Father's Name (First, Middle, Last) MAURICE BENSON GRAHA		e (First, Middle, Maid IRENE HA	
e, Maryland 1 and 2 should be file Health and Mental Hy em 27 is marked oth		1.11	ing Address (Street and Number or Rui		y or Town, State, Zip Code <mark>2</mark> 1157 TMINSTER, MD
S 5 = 0		4 □ Donation 5 □ Other (Specify) LAKE VIE	w MEM. PARK 2/4	/09 EL	Location - City or Town, State  DERSBURG, MD
Baltimo permit. Page Department of Irriportant: If any injury or			254 E. MAIN ST.	, WESTMI	
Physician /Medical Examiner		23a. Part1 — If the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	V:	or respiratory arrest,	Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.			
Vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certifi r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P equires that en signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
of Vital Records, Physician: The law requires the cardificate has been signed retail director, page 2 should be on	Completed			24a. Was an autopsy performed 1 □ Yes 2 □	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes   2   No
Vital F sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital:	Othory	th (Check only one)	JOSEPH HOGER CO.
sion of Vita anding Physician: ar: After this certific ne funeral director,	ation: To	1 Yes 2 No roughtation 2 ER/Outpati  27. Manner of Death 1 Natural 5 Pending 2 Accident Roughtation 2 Sa. Date of Injury (Month, Day, Year) 28b. Time Injury		28d. Describe how in	6X1Other (Specify)HOSPICE
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St	
Div To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical	29a. Certifier  (Check only one)  1	ath occurred at the time, date and place investigation, in my opinion, death occu	rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)  Date signed (Month, Day, Year)
<b>●</b>		1 Styl Show	1000335		2/2/09
4		30. Name and address of person who completed cause of death (Item 23a) (Type STEPHEN SIKORSKI, MD 912 WASH)	o, Print) NGTON RD., WEST	MINSTER	MD 21157
Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			1110

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** JANUARY 252009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMOR E 5. Social Security Number 6. HOSPITAL 6. Sex 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 □ F Months 214.58-9499 56 Carolina NORTH Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County oriant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 DYes 2 No tomore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) elder Bethlehan IX 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve once. Pages 1 and 2 should be ပ 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Belvedie Keginald Balto MD Drother 3216 HVE boid-Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Deurial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 30/2009 4 □ Donation 5 □ Other (Specify) 2. Name and Address of Facility 21. Signatur, f uneral Service Licens Howell Funeral Home Hahts MD 21207 Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 24 HR5 HEMOPERICARDIUM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ETASTATIC CUNG CANCER MONTH Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte be detached for in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Junknown page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy certificate 2□ No Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1/0 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this Q 28a. Date of Injury (Month, Day 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tes 2 🗌 No death. 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and itle of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 900 ANDREAMO ATON BAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 February Mary Gannon Etson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔯 F **Director** Jan 28, 1929 097-22-8788 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Is marked other than "natural" or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD Carroll Sykesville 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 1599 Homeland Drive E-1 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exprone. 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Francis Gannon Kathleen Nolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Timothy J. Gannon (Executor) 5 W. Myrtle Street, Alexandria, VA 22301 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maplewood Cemetery UNK Camillus, NY 22, Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 21. Signature of Funeral Service Licensee Buan L. taucut M00764 23a. Part 1. Enter the disease, or complicatives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** as /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 H Unknown Be Completed 24a. Was an autopsy performed? 1 □Yes 2 🗷 No 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760 Division of Vital Records, P.O. To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

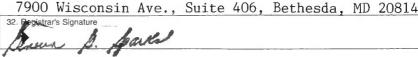
> State Registrar

DHMH 17 Rev 1/2001

Mahboob Ashraf, M.D.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



and manner stated.

AHTSOOB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** GERALDINE ELLIS JANUARY 2009 8:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under **Funeral** 1□ M 2 7 F Months Davs Hours 438-90-4276 LOUIS AWAS Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event the 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD FREDERICA 1 Yes 2 □ No Director FREDERICR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MARBLEWING COURT USA 21703 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SUNTRUST BANK 2 yr Trans Elementary/Secondary (0-12) BRANCH ASSISTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PARKER HENRY ATKINS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TREDERICK MAD 21703 tuis 1125 604 MARBILLUM 6 CT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State BATON POUBL LINES. WILLERO MOM, PK 2-709 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 6 ARY L. ROLLINS FUN, HOME Rollis PREDERIKK MD 21701 SOLAY ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner static Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to or as a consequence of Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ZNo 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Pleotitin 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗷 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 09 MD MD 51610 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederic 21702 AUR awas 82. Registrar's Signature 31. Date filed (Month, Day, Registrar

DHMH 17 Rev 1/2001

09-00843 Adam Folks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

CUATT FOIKS		- For State Registrar	aryland / Departin Certific	cate of Death	and Mentarin	Reg	, No. 200	9 02515	
Physicia Medical Exami		Decedent's Name (First, Middle,Last)     Adam	Folks			Date of Death     Month     January 28		3. Time of Death 1648 hrs	
		4a. Facility Name (if not institution, give street Upper Chesapeake Medical Ce		4b. City, Town Bel Air	n, or Location of Death		4c. County of Death Harford		
Funeral Director			7. Age (In yrs. last b	-	Year If Under 24Hrs Days Hours Min	_	Foreig	hplace (State or n untry)Maryland	
v any	ł	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow					10d. Inside City Limits	
re Maryland or 28a-f show fied at once.	ctor	Maryland Harford  10e. Street and Number	J	oppa 10f. Zip Co	de	10	g. Citizen of What Country?		
ith the Ma 23a or 28 notified	I Director	100 Bridge Drive			21085		USA		
r death w or items	Funeral		Vas Decedent Ever in U.S. rmed Forces? Yes 2 X No Give Year	If Yes, specify C	of Hispanic Origin? (Spuban, Mexican, Puerto No specify:		14. Race - Americ White, etc.		
hours aft natural Examin	ed by	15. Decedent's Education (Specify only high	est grade completed) 16a	a. Decedent's Usual Occ during most of working	cupation (Give kind of		16b. Kind of Business/II		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	12 years	bliege (1-4 or 5+)	Delivery			Papa Johns	s Pizza	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  Joseph William Folks		¥		e (First, Middle, M ynn Bowe			
T. 2 8 5 5 1		19a. Informant's Name/Relationship (Type, Pr Teri Lynn Young		9b. Marling Address (3			-		
Baltimore, MD 2 permit. Pages 1 and 2 shour Department of Health and Important: If item 27 is unjury or other tranmatic.		20a. Method of Disposition  1 Burial 2 XCremation 3 Rei	20b. Place	e of Disposition (Name of atory or other place)	Jan	uary	20c. Location - City or	Town, State	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Specify: 21 Signature of Funeral Service Dicensee	Bayvı	ew Cremato		, 2009	Baltimore,		
		23a./Part I) Enter the disease, or complication	s that caused the death. Do	7110 So	y Funeral llers Poin	t Road,	Dundalk, P. A Dundalk, Md.	21222 Approximate Interval	
Physician /M_cical Examiner		Mailure. List only one cause on each ine Immediate Cause (Final disease a. Conta	act Gunshot Wound o		ymg, oddr do odi dido c	, roop latery and		Between Onset and Death	
		or condition resulting in death)  Due to  Sequentially list conditions,  b.	(or as a consequence of):						
	Examiner		(or as a consequence of):						
uted nd ransit		events resulting in death) Last Due to	(or as a consequence of):			-			
60, ate be exectly six in the burial - t	Medical		NDED						
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi		IF FEMALE: 23c. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnance Live birth Pregnant at time of death	2 Fetal death	3 Ectopic pregna	ancy	23d. Date of delivery  Month	y Day Year	
Box 687  The death certification is the attending properties of the attending properti	Physician/	1 Yes 2 No 9 Unknown 9	Unknown	5 Other (Specify,		02- 8:4		About the state of the state of	
ires that the d signed by the	ē	Part II. Other significant conditions contri	buting to death but not result	ing in the underlying ca	use given in Part I.	1 Yes	2 No 3 Prob	the cause of death?  pably 4 ✓ Unknown	
cords, law requir	Completed					24a. Was a autops perforr	y prior to c	topsy findings available completion of cause of	
tal Rec		25. Was case referred to medical		26.1	Place of Death (Check	1 Yes 2		es 2 No	
Vital Inspiration:	To Be	examiner?  1 Yes 2 No	I Inpatient 2 V LR/	Outpatient 3 DOA			Residence 6 Other	:	
ion of tending Pheath		1 Natural 5 Pending	(Month, Day Year)		. Injury at Work? Yes 2 ✓ No	Subject shot	ow injury occurred self		
Division of Vital Records, P.O. Box 68760,  Hospital or Atteuding Physician: The law requires that the death certificate be executed.  24 hours after death  Funeral Director: After this certificate has heen signed by the attending physician and retain fulled in by the funeral director, page 2 should be detached for use as the burial - trans	ertification:	Suicide Could not be determined	Be. Place of Injury - At home, Specify) home	farm, street, factory, of	fice building, etc.	28f. Location (S or Town, St 100 Bridge Dri	treet and Number or Ru ate) ve, Joppa, MD	ral Route Number, City	
Division  To the Hospital or Atteution within 24 hours after death To the Funeral Director: /	Medical Ce	29a Certifier 1 Certifying Physician: To	the best of my knowledge, on the basis of examination and/o			d due to the cause	e(s) and manner as state		
To with	Med	29b. Signature and title of certifier	nanner stated	29c, L	cense number		29d. Date signed (Mo.	nth, Day, Year)	
d		Throstone M. K.s.	The me	ELD	).C.M.E. <b>0</b> Cl	ME	January 30, 2009	9	
5		Theodore M. King, Jr., MD.	ssistant Medical Exa	miner 111 Penr	Street, Baltimor	e, MD 21201			
St Regist	ate	31. Date filed (Month, Day Year) FEB 0 2 2009	32. Registrar's Signature	ake					

			Please						e All Copie		3		
		For State Registrar		State of	Marylan		artment of F rtificate of		nd Mental H	ygien Reg. No	0000	n:	2516
Physic	ian	1. Decedent's Name (	First, Middle, La	ast)	_				2. Date of D				ne of Death
/Medi	cal	DANIEL		RVIN	FINK		4h Cib. Taum		Jana	M 2	8 200	9 0	414 M
Exami	ner	4a. Facility Name (If no	H750t	u of P	4 4	rare	4b. City, Town, o	MORE	- Catu	9 40	c. County of De N/A	ath	
Funeral Director		5. Social Security Num 212-22-24 Usual Residence of De	.97		7. Age (In yrs. 82		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B (Month, D 10/28)	lay, Year	9. Bi	country)	tate or Foreign
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		10a. State	0b. County		10c. Cit	y, Town or Lo							de City Limits
ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must be notified at	Director	MD	BALTIM	10RE			BALTIMOR	E					Yes <b>X</b> ∏ No
with t		1313 SAD		, DUVD			10f. Zip Code	21208		10g. Ci	itizen of What C	ountry?	
death	Funeral	13 13 SAD	DLEBACK	12. Was Dece	dent Ever in U	.S. 13.			? (Specify Yes or Note of Rican, etc.)	10-	USA 14. Race - Am		ın,
after or ite		1 Never Married	/ \	Armed Fo	2 □ No e	1	ir Yes, speciny Cub 1 □ Yes 2 <b>1</b> 2 No	Specify:	uerto Rican, etc.)	H	Black, Wh		
hours tural	ed by	3 ☐ Widowed 4 [	□Divorced  5. Decedent's E	Year or Da	ites:	16a Dece	dent's Usual Occur	nation		16b k	Kind of Business	WHITE	
nin 72 In "na Medic	plet	(Specify Elementary/Second	only highest gr	ade completed)  College (1	-4or 5+\	(Give	kind of work done DO NOT use retire	during most of	f working	100. 7	vind of business	s/industry	
ed with ygiene Ier tha	Completed			4.			OWNER				C BOX C	'NA 9MC	Y
i be fill ntal H ed oth	Be	17. Father's Name (Fin		,	ET T.N	112			Name (First, Middle		,		
should nd Me mark mark	P	19a. Informant's Name		Type. Print)	FIN	_	ng Address (Street	and Number of	r Rural Route Num		LANDAY or Town, State,	Zip Code)	
and 2 ealth a n 27 Is		MERILYN FI	NK / WI	FE			SADDLEBA	_			MD 2120		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		20a. Method of Dispos		Removal from S		Place of Disponentery creed HE	sition (Name of matery or other place NAH =	ce)	Date		ocation - City o		te
it. Pa Intmen Intant: Injury		4 □ Donation 5  21. Signature of Fune	_			₹Z CHA	IM CONG.  Name and Addre	<u> </u>	30/2009		LTIMORE		
Depa Impol any it		21. Olgina die obs une	Dea	7	11/	/		ERSTOWN	SOL LEVII LROAD PI		& BROS. VILLEN		
		23a. Part1. Enter the shock, or heart f	disease, or con allure. List only	hications that ca	used deat				rdiac or respiratory		<u> </u>	Approx	
Physician	П	Immediate Cause (Fir disease or condition resulting in death)	nal	a. 80	FISHICK	ax	arrest	/dist	ress			Onset 24	and Death
/Medical Examiner		resulting in death)	- (	Due to (	or 🔭 a conseq	uerice f):	· Any to	wo .				_	-1 -1 -1
	Jer	Sequentially list condi- if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	tions, ediate	b. Due to	or as a nseq	uence of):	racio	مار		. 0	OLV WILL	0	days
xecuted and Il-transit	xaminer	Cause (Disease or injuthat initiated events resulting in death) Las		cM	otar	veni	de co	Alision	) pit	all	OL VO	6	days
	Ш	roodking in doddiny Edd		Due to (	or as a conseq	uence of):		(	DEALER HAS ALLER OF THE STATE O	THE WE	DICAL EXAM		
ificate g phys as the	edic			d					APPRO	ED p.			
leath certific attending p I for use as i	an/M	IF FEMALE: 23b. Was decedent pr		23c. If yes, out	come pf pregna rth 2 ☐ Feta		Ectopic pregnancy	v	CERTIFIC	1	23d. Date of de	livery	
The law requires that the death certificate be eate has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medical	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown			ant at time of d		Other (specify)				Month	Day	Year
res that the de signed by the a be detached	by Ph	Part II. Other significa	nt conditions	contributing to de	ath but not resi	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute t	o the cause	of death?
w require been sign	ted					_			_ 1	Yes 2	<b>Q</b> No 3□F	robably	1 □Unknown
The law cate has b	Completed		-							s an opsy formed?	24b. Were a prior to death?	utopsy findi completion	ngs available of cause of
	ပိ	25. Was case referred	to medical		110			26 Place of	1  Yes  Death (Check only)	2 No		3 2XN0	
hysici, nis cer I direct	To Be	examiner? 1 Yes 2 No		Hospital:	npatient 2 🗌	ER/Outpatier	t 3 DOA Oth	er.	ng Home 5 ☐ Res		6 □Other (Spe	ecify)	
ing Pa		27. Manner of Death  1 ☐ Natural	5 ☐ Pending	14.3 1	n, Day Year)	28b. Time of Injury	Wor		28d. Describe				4
Attend death ctor; / ctor; /	icati		investigation 6 ☐ Could not b	01/20	/2009	me, farm, str	) M 1□ eet, factory, office	Yes 2 No	28f Location		nd Number or Fi		(N) [21
al or A s after al Dire	Certification:	4 Homicide	determined	buildir	ig, etc. (Specif OCOL S	v), ,	,,,		City or To	own, State	e) old con Ct. Rd. Pi	r+ Adi	and _
To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director. After this certified completely filled in by the funeral director, I	Medical (	29a. Certifier 1 (Check only 2 one)	Certifying PI	nysician: To the miner: On the ba and mann	sis of examina	wiedge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and popinion, death	place, and due to the occurred at the time	e cause(s	and manner a	s stated	
To the within To the comp	×	29b. Signature and title	e of certifier	0	$\overline{}$		29c. Licens	e number		29d. Da	ate signed (Mon	th, Day, Ye	ar)
1			am	F. K	gut	4		-000	)	Jai	may	-28	2004
Y		30. Name and a week	of person who	completed sus	of death (Ite	23a) (Type,	Print)	Hox at	2, 1,-	12.	1 traval	)	
Sta	ate	31. Date filed (Month,	Day, Year)	32. Re	egistrar's Signa	ture	JI W	MOSK!	14 0	M	TIMA		
Regist	rar	FEB 0	2 2009	Breeze	J.	park	1						

1 ☐ Yes 2√∑ No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

State of Maryland / Department of Health and Mental Hygiene 02517 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 January 29, 2:00 AM Gossman 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death N/A Baltimore Overlea Health & Rehab if Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Months Davs Hours 1 □ M 2 🕅 F Yrs. January 10,1915 Maryland 10d. Inside City Limits 10c. City. Town or Location 1 XYes 2 No Baltimore N/A 10f. Zip Code 10g. Citizen of What Country? 106 N. Kenwood Avenue 21224 Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian.

**Funeral** Director permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel hygiene. Important: If them 27 is marked other than "natural" any injury or other traumetic averages.

**Physician** 

/Medical

Examiner

Angelina

5. Social Security Number

216-28-1424

10e. Street and Number

10a. State

Funeral Director

Be Completed by

Maryland

6 years

Usual Residence of Decedent

1 Never Married 2 Married

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

Michael Timpano

Frances Wilson

31. Date filed (Month, Day, Year)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licenses

10b. County

15. Decedent's Education (Specify only highest grade completed)

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

Daughter

32. Registrar's Signature

**Physician** /Medical Examiner

Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed buriel-trensit Medical Certification: To To the Hospital or Attendii within 24 hours efter death. To the Funeral Director: A completely filled in by

Division of Vital Records, P.O. Box 68760.

1	Michony	Connel	7110	Sollers Poir	nt Road, Dundalk	,MD. 21222				
	23a. Part1. Enter the disease of comshock, or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not enter the r	node of dying, such as cardi	iac or respiratory arrest,	Approxima Interval Be Onset and				
	Immediate Cause (Final disease or condition resulting in death)	· Cardio	//	nary all	est	1				
	Sequentially list conditions, if any, leading to immediate	. Hype	of as a consequence of a second consequence of as a consequence of	m						
	causé. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperus I demia Due to (or as a consequence of): Coronary artery disease								
			0	0						
	Part II. Other significant conditions	Contributing to death but not re	sulting in the underlyin	ig cause given in Part I.	23b. Did tobacco use co	ontribute to the cause 3 ☐ Probably 4 ☐				
	R	heumato	id are	toitis.	24a. Was an autopsy performed?	24b. Were autopsy available prior completion of of death?				
					1□ Yes 2 No	1 □ Yes 2				
ł	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)					
	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	DOA Other: 4 Jursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)				
	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred				
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fac	tory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Nu				
					ce, and due to the cause(s) and m curred at the time, date and place					
	29b. Signature and liftle of certifier	MB.		29c. License number D 253	201	ed (Month, Day, Year) 29 - 200				
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	ven Blud	, Bullino	e 102.				

Approximate Interval Between Onset and Death o use contribute to the cause of death? 2XNO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 ☐Other (Specify) ury occurred nd Number or Rural Route Number, s) and manner as stated. d place, and due to the cause(s) ate signed (Month, Day, Year)

Black, White, etc.

Specify: White

16b Kind of Business/Industry

20c. Location - City or Town, State

Baltimore, Maryland

Clothing

18. Mother's Name (First, Middle, Maiden Sumame)

Concetta Cutrone

February

2,2009

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.

106 N. Kenwood Avenue, Baltimore, Maryland

Registrar **DHMH 16 Rev 6/95** 

State

Baltimore, Maryland 21215-0036

Funera Directo

	1	For State Registrar		State o	f Marylan		•	rtment of l			lental Hy	gien Reg. No	e 2 (	009	02	2518
Physiciai /Medica	1		e (First, Middle, Las	'							2. Date of De Month	eath Da		Year 2009		e of Death 28 A M
Examine	r	4a. Facility Name (I	f not institution, give f Maylan	e street and nui	0.4	~		4b. City, Town, o Boutim 0	re			40		ity of Deat	th	
Funeral Director		5. Social Security N	lumbe <b>runk</b> 6. S	ex M∑M 2□F	7. Age (In yrs. 58		hday) (rs.	If Under 1 Year Months Days	If Und Hou	der 24 Hrs. Irs Min.	8. Date of Bir (Month, Di Jan 11	rth ay, Year 19	951	Co	thplace <i>(St</i> a ountry) .sylva:	te or Foreign nia
a-f show	İ	Usual Residence of 10a. State MD	Decedent  10b. County  Montgome	ery	10c. Cit			eation rsburg				T			ì	e City Limits ∕es 2 <b>X</b> No
23a or 28a	5	10e. Street and Nur 7827 Mun	mber icaster Mi	ill Road	10f. Zip Code				unk	10g. C		f What Co	ountry?			
0,"10	Dy ru	11. Marital Status 12 Never Marri 3 □ Widowed	ied 2 ☐ Married 4 ☐ Divorced	12. Was Dece Armed Fo 1 [X]Yes If Yes, Gi Year or D	ve 100		li li	Vas Decedent of Yes, specify Cub ☐Yes 2 🗓 No	an; Mex	dican, Puerto	ecify Yes or No Rican, etc.)	0-	В	ace - Ame lack, White city: wh		1,
ene. than "natur ne Medical	completed	(Special Special Speci	15. Decedent's Ed cify only highest gra andary (0-12)	I-4or 5+)	16a.	(Give I	lent's Usual Occu kind of work done DO NOT use retire repair	during r ed)			16b. l		Business/			
Nental Hygirked other	o pe co		(First, Middle, Last) upsmith			l			18. Mother's Name (First, Middle, Maiden Surname) Gertrude Schlesinger							
alth and N 27 is mai er traumal			ame/Relationship (		c			g Address <i>(Stree</i> .oslyn Co							Zip Code)	-
ant: If Item ant: If Item ary or othe		Gerald Grupsmith/brother  92 Roslyn Court Daly City, CA 94015  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Mother (Specify) in state													€	
Departr Imports any Inje		21. Signature of Euneral Service Science Director State Anatomy Facilities Board 655 W. Baltimore Street Baltimore, MD 21201														
ysician		Approximate interval Between Onset and Death  Due to (or as a consequence of):														
Medical aminer	er	Due to (or as a consequence of):  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):														
in and ial-transit	EXA	resulting in death) Last  Due to (or as a consequence of):														
g physic as the b	edical	d. Wemia														
ا ف غ	nysician/ime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   1 □ Pregnant at time of death 5 □ Other (specify)   9 □ Unknown									23d. Date of de Month			livery Day	<b>Ye</b> ar	
an signed build be deta	ed by Prny	Part II. Other signi	ficant conditions o	ontributing to d	eath but not res	ulting in	the ur	nderlying cause g	ven in Pa	art I.				ontribute to	o the cause robably 4	of death?
icate has bee	Completed										24a. Was auto perf 1 □ Yes		/	b. Were au prior to death? 1 □ Yes	completion	ngs available of cause of
s certif	o ne	25. Was case referexaminer? 1 ☐ Yes 2 🗓		Hospital: 1 TD	Inpatient 2	I FR/Ou	tnatien	t 3 DOA OI	hor:		n <i>(Check only</i> me 5 ☐ Res		6 🗆 0	Other (Sne	ocifu)	
ath. r: After thi	ation: 10	27. Manner of Deal 1 Natural 2 Accident		28a. Date (Mon		28b. T	ime of	28c. Inju			28d. Describe				cny/	_
s after de	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zee. Place	of Injury - At h	ome, far fy)	rm, str	eet, factory, office			28f. Location City or To			mber or R	ural Route I	Number,
in 24 hour he Funera pletely fill	Medical	29a. Certifier (Check only one)	1 Certifying Pr 2 Medical Exar	niner: On the b												se(s)
To t	M	29b. Signature and		aaya	is, m	D.		29c. Licer		ber 35AL812	20.			ned (Mont	th, Day, Yea	r)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Kinberse T. Adkurs, MD. 22 S. Greene Street Battimore, MD.  31. Date filed (Month, Day, Year)  FEB 0 2 2009  Registrar's Signature  January  J														
State Registra	-	31. Date filed (Mor	th, Day, Year)	9 En	Registrar's Signa	ure	par	Ked								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	•	,	ificate of L		vientai Hyg R	lea. No 2	009	02519
0	hysicia	an l	1. Decedent's Name (First, Middle, Last)				<del> </del>		2. Date of Dea	th Day		3. Time of Death
	/Medic	al	Edna M. Goodricl  4a. Facility Name (If not institution, give s				4h City Town or	Location of Death	January		2009	5:25p M
E .	xamin	er	233 Old Elm Road	reet and numbery			North Ea				cil	
	ineral rector		5. Social Security Number 6. Sex 212-22-0582	M 2 X F 83	(In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 4	Year) 1925	9. Birth Cou	place (State or Foreign ntry) MD
yland	MOL TE		10a. State 10b. County		10c. City, Town							10d. Inside City Limits
ле Маг	8a-f st	Director	MD Cecil		North E	East						1 □ Yes 2 No
th with th	23a or 2 ust be n	rai Dir	10e. Street and Number 233 Old Elm Road				10f. Zip Code 21901			USA	n of What Cou	ntry?
15-0036 172 hours after death with the Maryland	is a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give X Year or Dates:	ver in U.S.		as Decedent of Hi ∕es, specify Cuba ∐Yes 2∐ <b>X</b> \o	ispanic Origin? (Sp.n, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		Race - Ameri Black, White, pecify: Whi	etc.
<b>5</b> 27 1		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+	16a. E		nt's Usual Occupa nd of work done of NOT use retired omemaker	ation luring most of worl  )	sing		of Business/Ir estic	ndustry
a e a		To Be C	17. Father's Name (First, Middle, Last) George Taylor		Į.			18. Mother's Nam Edna M.	e (First, Middle, i	Maiden Su	irname)	
	item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)  Charles Goodrich Jr. (son)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 233 Old Elm Rd., North East, MD 21901									p Code)
Ore	<u>-</u> 5		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of E cemetery, A11 Cou	unty		lon   2-2-	09	Sykes	tion - City or T ville,	MD
<b>Balt</b> permit. Departr	Important: any Injury once.	, }	21. Signature of Funeral Service License Prograduight	Herbert	•	P.	O. Box 1	<sup>ss of Facility</sup> Hai 195 Sykes	ville, M	ID 21		
/Me	sician edical	discuss of condition										Approximate Interval Between Onset and Death
	miner	iner	Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury	Oue to (or as a	consequence of	ŋ:					Le .	
68760, ifficate be executed	physician <b>a</b> nd s the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):						
68760 tificate be	g phys as the	ledical	d.									
0	y the attending   ched for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mor 9 ☐ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	☐ Fetal death		Ectopic pregnancy Other (specify)	<i>y</i>		230	d. Date of deliving Month	very Day Year
<b>Records, P.O</b> The law requires that the	speen signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death bu	t not resulting in t	the und	lerlying cause give	en in Part I.	23e. Did to			the cause of death?
<b>r Re</b>	ate has page 2	Completed	Hypertens	sidn					24a. Was a autops perfor 1 □ Yes	sy	24b. Were aut prior to co death? 1 ∐Yes	opsy findings available ompletion of cause of
VITS	certifi	Be	25. Was case referred to medical examiner?	ospital:			3 Dog Othe	DE:	th (Check only or		7	
of of og Phy	ter this neral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day			28c. Injury	4 ⊔ Nursing H y at	ome 5 Resid			ify)
Division of I or Attending Phy after death.	tor: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No	001			
DIVI al or A	I Directed in Dy	Certification:	4 ☐ Homicide determined	28e. Place of Inju- building, etc.	ry - At nome, farn . <i>(Specify)</i>	m, stree	et, ractory, office		City or Tow	treet and r n, State)	vumber or Hui	al Route Number,
Division of Vita  To the Hospital or Attending Physician: within 24 hours after death.	he Funera pletely fille	edical (	29a. Certifier (Check only one) 1 Certifying Phys	Ician: To the best of er: On the basis of and manner stat	examination and	death d/or inve	occurred at the tirestigation, in my o	ne, date and place pinion, death occu	e, and due to the or rred at the time, o	cause(s) a date and pl	nd manner as lace, and due	stated. to the cause(s)
To t	To t	M	29b. Signature and title of certifier	1/2	011	11	29c. License	e number		29d. Date s	signed (Month	Day, Year)
1	)		30. Name and address of person who co	mplete cause of de	eath (Mem 23a) (T	Type, Pi	rint)	Kton	AN	Àl:	921	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 20	- A	r's Signature	1	all					

Physician /Medical Examiner									
F	ire	at	al or	_					
	ns 23a or 28a-f shov	must be notified		eral Directo					

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

-	1 - State Registrar	Certificate of Death	Reg. No. 2009 0252	20					
sician	1. Decedent's Name (First, Middle, Last)	Gerrity	Date of Death     3. Time of Dea						
edical miner	4a. Facility Name (If not Institution, give street and number)  The Johns Hopkins Hospital	4b. City, Town, or Location of De Baltimore City  Slast birthday) If Under 1 Year I If Under 24 F	ath J 4c. County of Death N/A						
ral tor	077-30-6890 1 M 2 xF	s. last birthday) 71 Yrs.  If Under 1 Year If Under 24 F Months Days Hours M		reign					
ctor	Usual Residence of Decedent  10a. State 10b. County 10c. C  P'ennsy:Lvania Bucks	City, Town or Location Plumstead Townsh	ip 10d. Inside City Li						
al Director	10e. Street and Number 4771 Essex Drive	10f. Zip-Code 18902	10g. Citizen of What Country? USA						
once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 □ Yes 2 ▼ No Specify:	(Specify Yes or No- erlo Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White						
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1.2	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Office Manager	working  16b. Kind of Business/Industry  Insurance						
To Be Co	17. Father's Name (First, Middle, Last) Richard Hippe		Name (First, Middle, Maiden Surname) othy Austin						
	19a. Informant's Name/Relationship (Type. Print) Michael H. Gerrity		r Rural Route Number, City or Town, State, Zip Code)						
	1 → Burial 2 ☐ Cremation 3 ☐ Removal from State	o. Place of Disposition (Name of cemetery, crematory or other place) renchtown Cemetery	Date 20c. Location - City or Town, State Frenchtown, New Jers	sey					
опсе	21. Signature of Funeral Service Licenses  23a. Part 1. Enter the objects, or complications that paysed the de		Stallings Funeral Home, P. ad, Pasadena, MD 21122  diac or respiratory arrest. Approximate	. A .					
an eal	shock, or heart failure. List only one cause on each line.	PSIS	Interval Between Onset and Deat						
er ច	Sequentially list conditions, if any, leading to immediate  Due to (or as a const	·							
Medical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a conse	equence of):		ersey P.A.  teleween Death  Year  death? Unknown available cause of					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	etal death 3 🗌 Ectopic pregnancy	23d. Date of delivery Month Day Year						
d by Ph	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unkn						
Completed			24a. Was an autopsy findings avail prior to completion of cause death?  1  Yes 2 No 1 Yes 2 No						
Be C	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital: 1 \( \subseteq \text{Inpatient} \) 2	Othor	Death (Check only one)						
ation: To	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	28b. Time of   28c. Injury at   Work?   1   Yes   2   No	28c. Injury at Work?  28d. Describe how injury occurred						
Certification:		home, farm, street, factory, office cify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
0	29a. Certifier  (check only and lace, and due to the cause(s) and manner as stated.  29a. Certifier  (check only and lace, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
dical	one) 2 Medical Examiner: On the basis of examinand manner stated.			Sey A.  reighth					
Medical Certification: To Be Completed by Physician/M	one) and manner stated.  29b. Signature and the discertified	29c. License number	29d. Date signed (Month, Day, Year)						
Medical	one) and manner stated.	RES 000	29d. Date signed (Month, Day, Year)  January 29 2009  North Wolfe St, Baltimore, MD, 21						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien ?

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GOSSA GE 11:30Am **Physician** SHIZUKO TRADU 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PREDERICK FRED GRICK 426 WEST 50071+ 51 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 78 213-42-5933 Months Days Hours Min. 1 □ M 2 🗹 F Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and the public of once. 10a. State 10c. City. Town or Location 10d. Inside City Limits FRED GRICK MO FREDERICK 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 50 UTH U.S 4 WEST 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) C PENNEY Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNIC) ဂ္ (UNUK) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (DAU) SUSAN M. GOSSAGE 50 WH ST PREDERICK MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMINISBURG CROM, Feb 2, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. IROME 21. Signature of Funeral Service Licensee FREDERICH MO 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Schenosis onowany motory ATHENO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UA Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 **V** No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 47951 02.02-0 - HN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 Toll, House Ave FreDERIUL >115° 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9,10c-f,15side of Maryland / Department of Health and Mental Lygien A 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 01 1026 A.M. 09 Sanok Hoeelund /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington
5. Social Security Number Hospital Montgomery Takoma Park Adventist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 💢 F 213-54-5298 75 Jan 18, 1934 Korea Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at Silver Spring 1 ☐ Yes 2√ No MD Montgomery Takoma Park Director 10g. Citizen of What Country? 10e. Street and Number 9211 Wire Avenue 10f. Zip Code "natural", or items 23a or 20912 20901 7525 Carrell Avenue USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify asian Specify: þ 3 XWidowed 4 ☐ Divorced Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Homemaker 12 Own Home unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be Kim Dong Syk **Pyon Yong Soon** 2 19a Karen Andrews Meeceint) Washington Adventist Hospital 19b. Maijing Oddras Greet and Arabada Tari Extandra Limmo 56 308 Zip Code)
7600 Carroll Avenue Takoma Park, MD 20912 Place of Disposition (Name of cemetery, crematory or other place) Feb. 02, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 2 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria ,Virginia 4 Donation 5 Mother (Specify) in-Name and Address of Facility rancis 1, Collins Fun. Home Inc. 21. Signature of Funeral S. nuce Licensee 500University Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or ella consequence of): Physician disease or condition resulting in death) /Medical Bullous Pemphicoid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Examine Preumonia Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ► No Day Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 No 3 Probably 4 → Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 **XX**o 1□ Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2<u></u> No 2 R/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Anatural (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled

Examiner or Attending Physician: The law requires that the death certificate be executed uiter death. Division or Vital Records, P.O. Box 68760, after death. Director; After To the Hospital o within 24 hours aft To the Funeral Di

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garcia

7600 Ave !

Takoma Park, MD

29d. Date signed (Month, Day, Year)

01/21/2009

31. Date filed (Month, Day, Year) State Registrar

Medical

29a, Certifier

29b. Signature and title of certifier

FEB 0 2 2009

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

F60914134

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Carroll J. Hildebrand JANUARY 7:20F M 22, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, May 27, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 💢 M 2 🗆 F 96 Maryland 216-01-5547 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, "he Medical Examir or must be nothind at 1X Yes 2 No Directo MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5703 Benton Heights Avenue 21206 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) accounting clerk financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill thent of Health and Mental H tant: If item 27 is marked ot Joseph Hildebrand Mamie Roth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie D. Hildebrand/spouse 5703 Benton Heights Avenue Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service ROTTa 1 C Sicensee 22 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 3a. Park . Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shoch or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PLURAL EFFUSION /Medical Due to (or as a consequence of): Examiner ACUTE MYOCARDIAL INFARCTION Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed signed by the attending physician and the detached for use as the burial-transit FIBRILLATION ATRIAL Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 23d. Date of delivery Hospital or Attending Physician: The law requires that the death 44 hours after death.

Funeral Director: After this certificate has been signed by the atten 3 
 Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been siç ; page 2 should b 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 □ Yes 2 0 1 □ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 2 No Hospital: မ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D ath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral Di 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D31674 address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) 32 Registrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

FEB 0 2 2009

09-00053 Sonia Harden

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 02524

		1- For State Certificate of L	Death	Reg	. No.		
Physici	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month	3. Time of Death		
ledical Exami	ner	Sonia Harden		January 2,	2009 1715 nrs		
			. City, Town, or Location of De Reisterstown		4c. County of Death Baltimore County		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 220–30–4868 7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birth July 3	(MM/DD/YYYY) 9. Birthplace (State or 1, 1924 Foreign Country) England		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentell Hygiera. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State	Decedent of Hispanic Origin? ( s, specify Cuban, Mexican, Pue  ZX No specify: S Usual Occupation (Give kind of the working life. DO NOT use of the working life. DO NOT use of the working life. Standard Number of Marie  Address (Street and Number of Adams Drive Hat	Specify Yes or Norto Rican, etc.)  of work done retired)  me (First, Middle, May Josephine or Rural Route Numb mpstead, N	10d. Inside City Limits  1 Yes 2 X No  3. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: white  16b. Kind of Business/Industry  healthcare aiden Surname)  e Swarbrick  per, City or Town, State, Zip Code)		
Baltimore, washing permit Pages I at pages I		1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify:  21. Instaur: Funeral Se. ce Licensee S. W. d. Director  22. Nature State  22. Nature State  22. Nature State  23. Nature State  24. Nature State  25. Nature State  26. Nature State  27. Nature State  28. Nature State  28. Nature State  29. Nature State  29. Nature State  20. Nature State  20. Nature State  20. Nature State  20. Nature State  21. Nature State  22. Nature State  23. Nature State  24. Nature State  25. Nature State  26. Nature State  27. Nature State  28. Nature State  29. Nature State  29. Nature State  20. Nature State  21. Nature State  22. Nature State  23. Nature State  24. Nature State  25. Nature State  26. Nature State  27. Nature State  28. Nature State  28. Nature State  29. Nature State  29. Nature State  29. Nature State  29. Nature State  20. Natur	me and Address of Facility te Anatomy Boa timore MD 21 mode of dying, such as cardia	rd 655 W. 201	Baltimore Street		
760, icate be executed physician and the burial - transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.					
	Completed by Physician	Completed by Physician	hysician	Pregnant at time of death	death 3 Ectopic pre		23d. Date of delivery  Month Day Year  acco use contribute to the cause of death?
Records, P.( The law requires that cate has been signed page 2 should be det			25. Was case referred to medical	26.Place of Death (Che	1 Yes  24a. Was ar autops perform 1 Yes 2	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?	
/ital siciar is cert lirecto	a	examiner? Hospital: 4 Inselient 2 FR/Outpatient	Othor		tesidence 6 🗸 Other: Scene		
Division of Vital I Hospital or Attending Physician: 24 hours after death. Fineral Director: After this certificity filled in by the funeral director,	tion: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury			ow injury occurred		
Division Hospital or Attendi 24 hours after death. Funeral Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, (Specify)	factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City ate)		
the hin the	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only one) 2 Medical Examiner: On the basis of examination and/or investigatio					
To To con	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)		
		Pineti Pruthall, MD	O.C.M.E.		January 23, 2009		
	1	30. Name and a dress of person who completed cause of death (Item 23a)	Ponn Street Politimes-	MD 24204			
	ل	Pamela E. Southall, MD Assistant Medical Examiner 111	Penn Street, Baltimore	, IVID 21201			
St Regist	ate trar	31. Date filed (Month, Day, Year) 2 2009 32. Repistrar's Signature for the state of	Kad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 06 M Year EUGENE JANUARY 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE SECOUR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 M 2□ F Nei Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1XYes 2 No nore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 🗓 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) nton ne 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow , State, Zip Code) 19a. Informant's Name/Relationship (Type. Date 20c. Location - City or Town. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenMount 21. Signature of Funeral Service Licensee Name and Address J. F. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DULMONARY EMBOLISM Due to (or as a consequence of): Sequentially list conditions, if any leading to limit data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 C Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I

Physician

Examiner

**Funeral** 

Director

or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten why Injury or other traumatic event, the Medical Exerciting DOS.

Physician /Medical

Baltimore, Maryland 21215-0036

event, the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

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Examine

Completed by Physician/Medical

Be

Certification: To

Medical

29b. Signature and title of certifier

death with the Maryland

/Medical

Part II. Other significant con	nditions cor			23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown			
					24a. Was an autopsy performed?		
25. Was case referred to medical				26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	F	lospital: 1 Inpatient 2 I	ER/Outpatient 3	DOA Other: 4 Nursing	ome 5 ☐ Residence 6 ☐ Other (Specify)		
	ending vestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
	ould not be etermined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fac	ctory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
29a. Certifier 1 Cer (Check only one) 2 Med	tifying Phy dical Exami	sician: To the best of my knoner: On the basis of examination and manner stated.	wledge, death occur ation and/or investiga	rred at the time, date and plac ation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)	

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 29c. License number 30272 THANKARY 27, 2009

millen BALTIMONE SECTIONS HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2009 Jackson Month Starr **Physician** Kamary 6:23 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 216-96-9129 FREDERICK Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director MO FREDERUK FREDERICK notified 10e. Street and Number 10g. Citizen of What Country ö must be 23a 01. 2 10 EAST MAIN Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian ral", or iter Examiner 1 Never Married 2 Married filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: RLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 4R. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be nd Mental P TACKSONI ပ 19a. Informant's Name/Relationship (Type. Print MCTLA) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ATT-101 FRED NO. 21703 ORCHARD TERRACE Health em 27 i 1155 20a. Methød of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Department of harmonization in the programment of harmonization of harmoni 1 ■ Burial 2 Cremation 3 Removal from State FREDERILL TAIRVIEW CEM JAN 23 2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUNCTION HORE GARY 1. Hollins FRED. MD. 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPITORTURY Arrest rours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SEPSIS Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 2' No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 🖾 npatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Yes 2 NO 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending P after death. Director: After t Injury 1 X Natural 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 2

State Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2009

Yenia

Rana

29b. Signature and title of certifier

The Johns Hapkins Hospita 1600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

medical obetor

225-000

29d. Date signed (Month, Day, Year)

January 19,2009

Amend #5 & 19a, per Inf G888 2/5/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year Physician 1234 AM KEEN DEWEY 2009 JANUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JAHNS HOPKING BAYNIEW MEDICAL CENTER BAUT IMPRE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. July 6, 1926 Birthplace (State or Foreign Country) 5, Social Security Number 265-36-5139 6. Sex 1 2 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Vrs Virginia Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 XNo Dundalk Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or : any Injury or other traumatic event, the Medical Eventher must be n. 21222 USA 1516 Leslie Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ∐Yes 2 X No Completed by 3 XWidowed 4 ☐ Divorced Vear or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Crane Operator 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clemey Keene Milton Keene ပ 19a. Informant's Name/Relationship (Type. Print)
Carlsen
Connie Renee Carlson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 7614 Poplar Avenue, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition February wards Chapel Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3, 2009 Randallstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service Licenses Inth 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final HOURS INJURY **Physician** HEAD resulting in death) /Medical Due to (or as a consequence of): Examiner 2 HOURS Sequentially list conditions, SENTIFICATION APPROVED BY MEDICAL EXAMINER Due to or as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last executed and burial-tra Due to (or as a consequence of): Box 68760 attending physician for use as the burla be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an STrak autopsy performed? 1 Yes 2 No has certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ပ္ After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Ulrector Afte completely filled in by the fun 1 Natural 1 □Yes 2 No SHAPED ON ICE 9:50 AM 130/09 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Lesje rd. Dundak mb 21227 HOME DRIVEWAY 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO028684 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward S. Bessman 4940 EASTERN QUENUE BASTI MORE

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

ORIGINAL

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21224

2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medi

FEB 0 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type Pint)

(axtud) 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

23

2009

State of Maryland / Department of Health and Mental Hygiene 02529 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30 Physician Month 19:01 P.M. KASEORU 2009 JAN UAR) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYVIEW MEDICAL CENTER JOHNS HOPKINS BALTIMORE If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 💢 F 218-42-5540 66 Director 09/14/1942 Estonia Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the "hadden Examination in each Director 1 ☐ Yes 2 No Lanham Prince George 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 U.S.A. 7004 Kingfisher Lane death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates; or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No ≥ Specify. 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 7; h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FOIA Researcher Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Selma Ratsep Uno A. Plank 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau 3313 Marlbrough Way, College Park, MD 20740 Karl Kaseoru, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/07/2009 Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Marandia Star 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY **Physician** disease or condition resulting in death) IMMEDIATE /Medical Due to (or as a consequence of): Examiner SEPSIS AND WEEK HYPOTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 1 WEEK The law requires that the death certificate be executed signed by the attending physician and a betached for use as the burial-transit ACIDOSIS ISCHEMIC COLITIS AND Due to (or as a consequence of): INTERVAL P.O. Box 68760, AMYLOID Physician/Medical DEPOSITION IN BOWEL DUE TO MULTIPLE MYELOMA UNKNOWN IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ate has been s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform certificate 2 **Z**No 1 ☐ Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this carriffman ours after death.

erai Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-30-2009 Û 30. Name and address of person who completed cause of death (item 23a) (Type, Print) ARIEL SPENCER 600 N. WOLFE STREET BALTIMORE U. MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician  $\underline{AM}^{M}$ 2009 412A-138+4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Dove House Westminster Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 2 7. Age (In vrs. last birthdav) 6. Sex Social Security Number **Funeral** Days Year, Months Hours 1 □ M 2 X F 1934 Connecticut 045304042 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Eventher must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Carrol manchester WI 1 ☐ Yes 27 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21102 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify. white Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) administrator education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be A. Marvin Laidlaw Esther C. Carrott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
292 Stoner Avenue WEstminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Dove House 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service S 21201 Baltimere, MD 23a. Pau 1. Enter the disease of complications that caused the show, or heart fillure. List only one cause on each line. r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) TORY **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettencing physician and or use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and fitle of 29d. Date signed (Month, Day, Year) D0029246 1-22-09 person who completed cause of death (Item 23a) (Type, Print) Hights Mal Ctr. Westminster, Mg 1157 224 SPARA Washington 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			1- State Registrar Amend Item 5 State of Maryland / Department of Health and M Certificate of Death	lental Hyg R	iene eg. N.2009	02531
D.		511	1. Decedent's Name (First, Middle, Last)	Date of Deam     Month	th	3. Time of Death
	Physici /Medic		Leona Thelma Minor	January	18, 2009	11:20 AM <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th
			Levindale Nursing Home Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Bir	thplace (State or Foreign
ь	Funeral Director		5 Social Security Number   6. Sex   1 M 2 F   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   4 Months   Days   Hours   Min.   4 Months   Days   Months   Days   Hours   Min.   4 Months   Days   Months   Days   Hours   Min.   4 Months   Days   Months   M	Month, Day,	Year) Co	yland
	pu ,		Usual Residence of Decedent			
	laryla shov	'n				10d. Inside City Limits 1√□Yes 2 □ No
	the N 28a-I	rect	MD Baltimore  10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	21
	be filed within 72 hours after death with the Maryland ntal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Merkal Examiner must be notified at	Funeral Director	2434 W. Belvedere Avenue 21215		USA	•
	ems 2	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spell if Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s after	by Fu	1  Never Married 2  Married 1  Yes 2  No	,	Specify: b]	
21215-0036	tural	ed b	3 Mathematical Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	T	16b. Kind of Business.	/industry
215	within 72 ene. than "ne he Me is	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	ing		,
21	filed wit Hygiene other tha	Com	12 0 pastry preparer	<u></u>	dept store	bakery
nd	be fill	Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name			
Maryland	2 should be and Mental is marked or and marked or animatic ev	T <sub>0</sub>	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura	ian Wado	<u> </u>	Zin Codo)
Ma	nd 2 s lith an 127 is i		Wallis Minor/daughter  626 Brisbane Road Bal			zip Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If Item 27 Is marked any Injury or other traumatic en		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☒ Donation 5 ☐ Other (Specify)	Date	20c. Location - City or	Town, State
Baltii	permit. F Departm Importar any Injur	Ì	21. Signatur of Euneral Service Licensee Ronal of Service State Anatomy Board		Baltimore	Street
			Baltimore, MD 2120  23a. Part 1. Enter the disease, of complications that aused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause of each line.		est,	Approximate
2	Physician /Medical		Immediat Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):			Interval Between Onset and Death
	Examiner					•
	ted 1sit	Examine	Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease or injury			
,	cate be executed physician and the burial-transit	Exan	that initiated events c			
8760,	te be ysicial	dical	d			
9	rtifical ng phy as th	Medi	IF FEMALE:			
.0. Box	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5  Other (specify)		23d. Date of de Month	livery Day Year
ds, P	ires that signed by d be deta	by P	Part Mother significant conditions contributing to death but not resulting in the underlying cause given in Part I.  [Dementu	23e. Did tol	bacco use contribute to es 2 Mo 3 □ P	o the cause of death?
COL	w requ	letec	desenerative arthritis	24a. Was a	7 -	
Division or Vital Records,	The law requires ate has been sign	Completed by	Ungerenagio Cavirii 1115	autops perfori	sy prior to med? death?	topsy findings available completion of cause of
ital	lan: rtiffica ctor, p	BeC	25. Was case referred to medical 26. Place of Death		2 <b>1</b> No 1 □ Yes	2 □ No
r V	Physiclan: r this certificatal director, I	To		me 5 ☐ Reside	ence 6 □Other (Spe	cify)
o u	ing P After t unera		1 Datural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	ow injury occurred	
isio	Attending r death. ector: After by the fune	icati	2 Accident investigation   M   1   Yes 2   No   3   Suicide   6   Could not be determined determined	28f Location (St	treet and Number or R	ural Route Number
Ω	s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Towi	n, State)	arai rroute (tumber,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, the desired physician in the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the c red at the time, d	ause(s) and manner as late and place, and du	s stated. e to the cause(s)
	Mithi Com	Σ	29b. Signature and title of certifier  29c. License number  29c. License number	2	9d. Date signed ( <i>Moni</i>	ih, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Was M-Ley Leywall 2434 WBells	were	21215	
ůκ	ہSta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature  FFB 0 2 2009 Annua B. Sparks	<u></u>		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William H. Mars Sr 05:10 AM 2009 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1200 Nottingham Road E1kton 8. Date of Birth (Month, Day, Year)
Dec 26, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F 73 1935 219-30-3579 Maryland Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
mart if item 27 15 marked other than "natural", or items 23a or 28a-f show mart if item 27 is marked other than "natural", or items 12a or 21a in any or other traumaft event, fire Medical Examination and items and other traumaft ovent, fire Medical Examinations. 1 ☐ Yes 2√☐ No MD Ceci1 E1kton Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1200 Nottingham Road 21921 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: white Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) music/collectibles salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harlan Mars Elizabeth Shaffer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delores Mars/spouse 1200 Nottingham Road Elkton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. 1.11. Enter the dise, se, or comp lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final Enl Stage **Physician** 42415 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or sele-consequence of) requires that the death certificate be executed and use as the burial-trai Due to (or as a consequence of): physician attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) a I Inknown 9 Unknown à s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate has page 2 autopsy performed 1 □Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No r death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 065902 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elkton Mo

State Registrar 31. Date filed (Month, Day, Year)

0 2 2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Barket

Calledrel
32. Registrar's Signature

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Physician/		Decedent's Name (First, Middle,Last)							2. Date of Death Month Day Year 1302 hrs		
dical Exàmine	r		Tamara	Sara	h Mus	grove	3	. January	27, 2009 4c. County o		
	4a	. Facility Name (if not institution	on, give street and nun	mber)	4	b. City, Town, or Lo Columbia	ocation of Dea	atn	Howard	·	
		5978 Turnabout Lane		7. 4 () 10:	at hirthday/	If Under 1 Year	If Under 24	Hrs. 8. Date of E	Birth (MM/DD/YYYY	g. Birthplace (State or Foreign	
Funeral	5.	Social Security Number	6. Sex	7. Age (In yrs. las		Months Days		Ain.	3-1963	Country) MD	
Director	2	212-84-8094	1 M 2 X F	46	Yrs.			1-23	-1903	HD	
	_	sual Residence of Decedent  Da. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits	
w any	10		ward	Col	umbia					1 Yes 2 X No	
Aaryland 28a-f show 1 at once.	<u> </u>	De. Street and Number		001		10f. Zip Code			10g. Citizen of Wi	hat Country?	
the Maryland a or 28a-f sh Liffed at once	] [					2104	4		USA		
th the notification of the control o		5978 Turnab		edent Ever in U.	S. 13. Wa	s Decedent of Hist	anic Origin?	(Specify Yes or I	No- 14. Race	e - American Indian, Black, e, etc.	
r items 23		Never Married 2			lf Y	es, specify Cuban,	Mexican, Pu	erto Rican, etc.)			
er de	<b>-  </b>	3 Widowed 4 XD	Divorced If Yes, Give Yes	2 <b>X</b> _ 140		Yes 2 X No				Black	
5-0036 led within 72 hours after death with the Maryland stylene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once the Medical Examiner must be notified at once the Medical Examiner must be notified at once of the Medical Examiner must b		15. Decedent's Education (Sp	or Dates: pecify only highest grad	de completed)	16a. Deceder	nt's Usual Occupati ost of working life.	on (Give kind DO NOT use	of work done retired)	16b. Kind of Bi	usiness/Industry	
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5-0036 led within 72 Hygiene. other than '	티	12th grade		I/A	Но	usekeep	er HO	me ame (First_Middl	e, Maiden Surnam	e)	
	۱ ا ت	7. Father's Name (First, Middl	<sup>ile, Last)</sup> Unk					rne Mus			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a R	19a. Informant's Name/Relation	anchin (Type Print )		19b. Mailin	g Address (Stree	t and Number	or Rural Route	Number, City or To	wn, State, Zip Code)	
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e, MD I and 2 sho Health and item 27 is	1	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of cer	netery,	Date	20c, Location	- City or Town, State	
More Pages 1 a nent of He ant: If ite		1 X XBurial 2 Cremati		rom State M	crematory or o	mel Cem	1	-31-200	9 BALTO	O, MD	
		4 Donation 5 Other 21 Signature of Funeral Servi	Specify:		22.	Name and Address	of Facility	March	East F	/H	
Baltil permit: Departm Importa injury o	1/		1 -0009	croll,	-	1101 E.	Nort	h Aveni	ie Balto	o, MD 21202	
Physician	-	23a. Part I. Enter the disease, failure. List only one cau	, or complications that	caused the death	n. Do not enter	the mode of dying,	such as card	liac or respiratory	arrest, shock, or h	Between Onset and	
execut an and al - tra	amin	if any, leading to immediate cause. Enter Uniderlying Cau (Disease or injury that initiate events resulting in death) La	d. AMENDED	a consequence a consequence 3 23a,27 s, outcome of pre	of):	g888 2/				of delivery	
iords, P.O. Box 68760, aw requires that the death certificate be executed and the bear signed by the attending physician and 2 should be detached for use as the burial - transit	Physician/N	23b. Was decedent pregnant in past 12 months?  1  Yes 2 No 9 ✓	unknown   1 Live	e birth gnant at time of c known	death 5	Other (Specify)	Ectopic p		Month	Day Year ntribute to the cause of death?	
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- i - i - i - i - i - i - i - i - i - i	훘									b. Were autopsy findings availat	
rds, v require	leted							24a. '		b. Were autopsy findings availat prior to completion of cause o death?	
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Il Records, II. The law require rificate has been si, tor, page 2 should b	e Completed	25. Was case referred to me					ce of Death (C	24a. 1	Was an autopsy performed? Yes 2 No	b. Were autopsy findings availat prior to completion of cause o death?  1  Yes 2 No	
Vital Records, ssician: The law require his certificate has been sidirector, page 2 should b	Be	examiner?	Hospital:	Inpatient 2	ER/Outpatio	26.Pla	ce of Death (0	24a. 1 V. Check only one) Nursing Home	Was an autopsy performed? Yes 2 No Residence	b. Were autopsy findings availat prior to completion of cause o death?  1  Yes 2 No  6  Other: Scene	
of Vital Records, ag Physician: The law require ther this certificate has been si neral director, page 2 should b	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2 ate of Injury	ER/Outpatie	26.Pla ent 3 DOA of injury 28c. In	ce of Death (Cother'4 jury at Work?	24a. 1 Check only one) Nursing Home 28d. Desc	Was an autopsy performed? Yes 2 No	b. Were autopsy findings availat prior to completion of cause o death?  1  Yes 2 No  6  Other: Scene	
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5   Accident  3  Suicide 6   4  Homicide	Pending Investigation Could not be determined (Special Examiner: On the base and manner)	ate of Injury onth, Day, Year)  lace of Injury - At  ify)  best of my knowl sis of examination	28b. Time of	26.Pla ent 3 DOA of Injury 28c. In 1 treet, factory, office courred at the time, igation, in my opini	oce of Death ((  Other;  jury at Work?  Yes 2  e building, etc  date and plat on, death occurred to the common death occurred to the	24a.  1 24a.  1 25.  Check only one)  Nursing Home  28d. Desc.  No  28f. Loca or To	Was an autopsy performed? Yes 2 No 5 Residence cribe how injury occurring the following state of the country occurring the following state of the country occurring the following state of the country occurring the country	b. Were autopsy findings availat prior to completion of cause or death?  1 Ves 2 No  6 Other: Scene curred  umber or Rural Route Number, Compar as stated.  Indicate the cause(s)  signed (Month, Day, Year)	
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 2 Accident  3  Suicide 6 4 Homicide  29a. Certifier 1 Certifyir (Check only one) 2 Medical  29b. Signature and title of control of the control	Pending Investigation Could not be determined Remainer: On the bas and mannivertifier  Pending Investigation 28e. P (Special Special S	ate of Injury onth, Day, Year)  Place of Injury - All ify) best of my knowl sis of examination er stated.	28b. Time of the thome, farm, so ledge, death or n and/or invest tem 23a)	26.Platent 3 DOA  of injury 28c. In 1 treet, factory, office coursed at the time, igation, in my opini 29c. Lice O.C.	ce of Death ((  Other <sub>4</sub> jury at Work?  Yes 2  e building, etc  date and plac on, death occurse number  C.M.E.	24a.    1   24a.   24a.   1   24a.   24a.	Was an autopsy performed? Yes 2 No 5 Residence cribe how injury occurring ton (Street and Numyn, State) a cause(s) and mar date and place, ar 29d. Date s January	b. Were autopsy findings availat prior to completion of cause or death?  1 Ves 2 No  6 Other: Scene curred  umber or Rural Route Number, Compar as stated.  Indicate the cause(s)  signed (Month, Day, Year)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2 30 pm Year **Physician** 2009 JAY /Medical 4b. City, Town, or Location of Death 4c. County of Deaty 4a. Facility Name (If not institution, give etreet and number) **Examiner** If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Eb 28) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. 1 □ M 2 🗗 9-28-1553 irginia Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Martical Exeminer rust be notified at once. 1 Nes 2 No Funeral Director saltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Hayward 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. Specify: Black <u>^</u> 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Emploi tomema 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ 19b. Mailing Address (Street and Number or Ritral Route Number, City or Town, State, Zip Code) 20143 Informant's Name/Relationship (Tipe. Print) Autumn Ellicott City, MD field herman 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Dwings Mills, MD Liarrison Forest Veterans! 29 2009 4 □ Demation 5 □ Other (Specify) 11 22. Name and Address of Facility Howell Fuxeral 21. Signature of Funeral Service Licensee 4600 MD 21207 Heights Liberty Hul, dr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 **Physician** 2008 /Medical Due to (or es a consequence of): Examiner 2008 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate had director, page 1 ☐ Yes 2 🔼 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2/1 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check enly one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur SILVAR 30. Name and a dreef of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON BLUD IUU32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Coscera

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh G888 2.10.09 TT
State of Maryland / Department of Health and Mental Hygiene

Continued of Death

1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 29, 2009 McConnaughy January 5:20 a Margaret F. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 213 High Meadow Road Reisterstown If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Yrs. 216-38-4298 67 26, 1941 Maryland Director Feb. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Baltimore Reisterstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exxurant must be no once. 213 HighMeadow Road 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No <u>გ</u> Specify: 3 Widowed 4 Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Safeway 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Ritzmann Dagmar ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward R. McConnaugh Husband 213 HighMeadow Road Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/09 Dulaney Valley Mem. Cockeysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reistertown Road ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final mouths **Physician** disease or condition resulting in death) /Medical ( Cardismy **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) n signed by the a Id be detached f 1 ☐ Yes 2 No 9 ☐ Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 □Yes 2 🗷 No 1 ☐ Yes 2 📉 No : After this certific funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Hospital: Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who om 1650 Ovleans St. CRB 1 Rm 289 But 21031 Johns Hopkins 31. Date filed (Month, Day, Year) State

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Evelyn Ruth Norris January 30, 2009 10:49 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**XX** Months Days Hours Yrs. Director 219-22-4236 82 Nov. 9, 1926 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other than "natural", or Itema 23a or 28a-f ehow traumatic event, me Madical Examinar musi be notified at 1 Yes 2XXVo Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 254 Candytuft Road 21136 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 22 10 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 þ Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental William Horak Agnes Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 James M. Norris (Husband) 254 Candytuft Road, Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Feb. 2, 20c. Location - City or Town, State Depertment of H Important: If its eny injury or of once. XXBurial 2 Cremation 3 Removal from State Meadowridge Mem'1 Pk. 2009 4 □ Donation 5 □ Other (Specify) Elkridge, Maryland Eckhardt Funeral Chapel, 11605 Reisterstown Road, P.A. Owings Mills, MD 21117 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Utren **Physician** Conce disease or condition 10820/BUL resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the ettending physicien and dbe detached for use es the burial-transit the death certificate be executed Due to (or as a consequence of): 68760. Physician/Medical Box ( 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 3 ☐ Probably 4 Donknown should I 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an spitel or Attending Physician: The law rours efter death. nerel Director: After this certificate has filled in by the funeral director, pege 2.1 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours eff To the Funerel DI completely filled in 1 Descritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and appress of person no completed cause of death (Item 23a) (Type, Print) 555 South Carter Street Westmisster, MD 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	State Registrar	C	ertificate of L	Death		Reg. No 2009	02537
			1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day Year	3. Time of Death
	Physicia /Medic		Virginia Harriett	Nash			Januar		10:05 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Deat	
1			377 Edgewater Road	<i>"</i>		Pasadena If Under 24 Hrs.	8 Date of Bir	Anne Ar	thplace (State or Foreign
	Funeral		1□M 2☑F	ge (In yrs. last birthdi 93 Yrs	Months Days	Hours Min.	8. Date of Bir (Month, Da March	iy, Yea <i>r)</i> Co	ountry) MA
	Director	-	220-66-1716  Usual Residence of Decedent	93			march	11 1010	TIM
	yland now		10a. State 10b. County	10c. City, Town or	r Location				10d. Inside City Limits
	Mar Ba-f st	눥	Maryland Anne Arundel		P	asadena			1 □ Yes 2 📝 No
	or 28	Director	10e. Street and Number	-	10f. Zip Code			10g. Citizen of What Co	
	23a		377 Edgewater Road			21122			SA
	tems	Funeral	11. Marital Status 12. Was Decedent Armed Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Ame Black, White	
36	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. F is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Exeminar hand be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Dates:	140	1 □Yes 2 ☑ No	Specify:		Specify:	White
Ş	atura		15. Decedent's Education	16a. De	ecedent's Usual Occup	ation		16b. Kind of Business	/Industry
215	e. an "na	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	5+) (G lit	Give kind of work done of the DO NOT use retired	during most of work f)	ing		
21	d with	5	12		Homemak			House	ehold
n		Be	17. Father's Name (First, Middle, Last)					, Maiden Surname)	
<u> </u>	Men Men Parker Parker	ပ္	Everett L. Growell			Blanch	Higg		
Nar	l 2 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)	-				er, City or Town, State,	Zip Code)
e,	1 and Healt em 2		Kenneth L. Nash (son)  20a, Method of Disposition	20h. Place of Di	Edgewater isposition (Name of	1	nsadena, Date	, MD 21122 20c. Location - City or	Town, State
Baltimore, Maryland 21215-0036	ages int of t: If it		1 Burial 2 Cremation 3 Removal from State	cemetery,	crematory or other place aven Cemete	i ren	. 02	Glen Burni	e, Maryland
	artme ortan Injur		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Livenstee	oren ne	22. Name and Addre	ce of English			
ä	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic et Once.		I Lun ) Sty of		3111 Mou			gs Funeral : adena, MD 2	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not					Approximate Interval Between
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	/Medical		resulting in death)	a consequence of):					
	Examiner	L	Sequentially list conditions. b. Tailw	e to this					
V	ed sit	ine	Sequentially list conditions, if any, reading to 1 in noditate cause. Enter Underlying Cause (Disease or injury	a consequence of					
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68760,	ificate g phy: ss the	Medical	U				-		
Вох	eath certific attending p for use as		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	e of pregnancy 2  Fetal death	3 Ectopic pregnanc			23d. Date of de	
B	death	sicia	1 Yes 2 No 4 Pregnant	at time of death	5 ☐ Other (specify) _	· y		Month	Day Year
P. 0.	at the de	Physician/	9 Unknown	The second secon		i- Dort I	220 Did	tobacco use contribute t	o the cause of death?
<u>ග</u>	w requires that s been signed I should be det	by	Part II. Other significant conditions contributing to death	but not resulting in tr	ne underlying cause giv	en in Part I.		,	Probably 4 Unknown
orc	requi	Completed							
ဒ္ဓင	e law has t e 2 s	nple					24a. Was		utopsy findings available completion of cause of
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₹	sician: The law s certificate has b lirector, page 2 sl	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Outp	ationt 3 DOA Oth	26. Place of Dea	11	idence 6 ☐ Other (Spe	noite)
Division of Vital Records,	g Phys er this eral dir	Certification: To	27. Manner of Death 28a. Date of In	ury 28b. Tin	ne of 28c. Injur			how injury occurred	жиу)
ion	nding tth. r: Afte e fun	ațio	1 Natural 5 □ Pending (Month, D 2 □ Accident investigation	ay, Year) Inju		k?  Yes 2 □ No			
Vis	il or Attending Phy after death. I Director: After this d in by the funeral d	tifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Ir building, €	njury - At home, farm	, street, factory, office		28f. Location City or To	(Street and Number or Fi wn, State)	ural Route Number,
Ö	pital or Al burs after o eral Direc filled in by	Cert		(-,,					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one)   t of my knowledge, of examination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	e, and due to the rred at the time	e cause(s) and manner a , date and place, and du	is stated. e to the cause(s)	
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certifier \( \)	tated.	29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	<b>5.≱ 6</b> 8		Mulane Achanel	CRNA	R	08605	3	01300	9
	1		30. Name and address of person who completed cause of	death (Item 23a) (To	ype, Print)			0	1
	9		Lois Jane Schramek CRN	P 213	Newport (	Time S	everna t	rack MO 21	146
	Sta	ite	31. Date filed (Month, Day, Year).	trar's Signature	- ·			ote and place, and du 29d. Date signed (Mon 0 1 30 6	
	Regist	ar	FEB 0 2 2009 Canada	p. goa	ile				

			For State of Registrar	Maryland		irtment of F tificate of i	lealth and N Death		iene <sub>9. No.</sub> 2009	02538
	Physici		Decedent's Name (First, Middle, Last)  June	O'Cc	nnor			2. Date of Death  January	1	3. Time of Death 5:00 A M
1	/Medic Examin		4a. Facility Name (If not institution, give street and nur	nber)		•	Location of Death		4c. County of Deat	
	Funeral		Stella Maris - Hospice  5. Social Security Number 6. Sex	7. Age (In yrs. lasi	t birthday)	If Under 1 Year	OWSON  If Under 24 Hrs.	8. Date of Birth (Month, Day,	Baltimore 9. Birt	hplace (State or Foreign
	Director		216–18–3244 1□M 2ÅF	85	Yrs.	Months Days	Hours Min.	March 6,	1923 Mai	ryland
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-f s	ecto	Maryland Baltimore  10e. Street and Number	D	Ounda.	10f. Zip Code		10	ng. Citizen of What Co	1 ☐ Yes 2 ZNo
	h with 1	al Dir	101 Center Place Apt 410				222		USA	and y:
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Widowed 4 ☒ Divorced  1 □ Ves If Yes, Giv	2X∏ No ∕e		Vas Decedent of H fYes, specify Cuba □Yes 2XNo	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
21215-0036	72 hou 'natura dical E	Completed by	15. Decedent's Education (Specify only highest grade completed)		16a. Deced (Give	ient's Usual Occup	ation during most of work f)	ing 1	l 6b. Kind of Business/	Industry
121	within iene. • than "	ршо	Elementary/Secondary (0-12) College (1 12 years	-4or 5+)		00 NOT use retired erical	1) -		Orioles Bas	seball
nd	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, Last)	•			18. Mother's Name		faiden Surname)	
ıryla	should nd Mer marke ımatlc	၉	William Hollar  19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	Ethel 3		City or Town, State, 2	Zip Code)
, <b>K</b>	and 2: lealth a m 27 is her trau		Sharon Torres Daught						ndalk,Mary	
Baltimore, Maryland	t. Pages 1 tment of H tant: If iter tjury or otl	J.	20a. Method of Disposition  1 ☐ Burial 2 Arcremation 3 ☐ Removal from 9  4 ☐ Donation 5 ☐ Other (Specify)		iew (	sition (Name of natory or other place Crematory	31,	2009 E	Raltimore,	Maryland
Bal	Depar Depar Impor any in	2 10	21. Signature of Funeral Service Licensee	elly	Ĉ	Name and Addre Onnelly F 110 Solle	uneral Ho rs Point	me of Du Road, Du	ındalk,P.A. ındalk,MD.	21222
		100	23a. Part 1. Enter the disease, or complications that conshock, or heart failure. List only one cause on e	aused the death.						Approximate Interval Between Onset and Death
	Physician / /Medical			STIVE HE		AILURE				
	Examiner	<u>.</u>	Sequentially list conditions, b.	or as a consequer						
V	cuted nd ransit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events	Ji as a consequer	ice or).					
,0928	ficate be executed physician and s the burial-transit	al Ex	resulting in death) Last Due to (	or as a consequer	nce of):					
w.	tificate ng phys as the	<b>ledical</b>	d							
O. Box	w requires that the death certif s been signed by the attending should be detached for use as	Physician/Me	in the past 12 months?	come of pregnanc birth 2☐ Fetal de nant at time of dea own	eath 3□	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
S, P.	The law requires that the ate has been signed by th bage 2 should be detache	þ	Part II. Other significant conditions contributing to de	ath but not resulting	ng in the ur	nderlying cause giv	en in Part I.		acco use contribute to	
Vital Records,	v requir been s should	Completed						1 ∐ Ye:	<del></del>	obably 4 Unknown
Re	2 8 2	ошо						autopsy perform	y prior to death?	completion of cause of
Vita	certifica rector, p	Be	25. Was case referred to medical examiner?			A A TI DOA Oth	26. Place of Deat	h (Check only one	9)	
J O	ding Physician: The h. h. After this certificate h. funeral director, page	n: To	27. Manner of Death 28a. Date	npatient 2 EF of Injury 28 th, Day, Year)	R/Outpatier  Bb. Time of  Injury	1 3 LI DUA	y at	ome 5 Resider 28d. Describe how	nce 6XOther (Spe w injury occurred	cify) HOSPICE
Division of	or Atten ifter deat Director: in by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home		M 1 □	Yes 2 □No	28f. Location (Str. City or Town,	reet and Number or Ro , State)	ıral Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier  (Check only 2 Medicel Examiner: On the boone)  Nurse Practition	asis of examination						
	To the within To the comple	Med	29b. Signature and title of certifier	or stated.		29c. Licens	e number	29	od. Date signed (Mont	h, Day, Year)
	/		* JYJANSLANT			1814	1792		1/30/09	
	5		30. Name and add ess of person who completed caus  JACKIE JONES, CRNP 2300	e of death (Item 23  DULANEY			TIMONIUM,	MD 2109	3	
	Sta		31. Date filed (Month, Day, Year) 32. R	egistrar's Signatur	е	41				
-	Registr	a!	FEB 0 2 2009 Send	in S.	1900	CAP.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD g888 2/27/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) James Henry Pindell, III 2. Date of Death 3. Time of Death **Physician** :35pM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Joseph Richey Hospice
5. Social Security Number 6. Sex <u>Baltimore</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept 16, 1 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☑ M 2 □ F 53 1955 Director 220-16-1553 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, it is Modical Exercities and be rutified anone. 1 ☐ Yes 2 € No Director Anne Arundel Annapolis MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21409 1204 Stonewood Court Funeral unk

12. Was Decedent Ever in U.S.
Armed Forces?

1 \_Yes 2\( \frac{\text{Y}}{\text{No}}\) No
If Yes, Give
Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify black Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed unk unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Ann Both James H. Pindell III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 4582 Annapolis, MD 21403 19a. Informant's Name/Relationship (Type. Print) Mike Lewis/brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Sunatura Funeral Sunice Licensee Ronal S. Wale, State Anatomy Board 655 W. Baltimore Street lirector Baltimore, MD 21201 Part 1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stag /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2. 🗹 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Henry Pindell 1 ☐ Yes 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 St Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? of or Attending Fatter death. 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIA Registrar's Signature 31. Date filed (Month, Day, 32. Year) State parket Registrar

2:35pm

James

State of Maryland / Department of Health and Mental Hygiene Reg. 2.009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** PerKins SALLY ion of Death 4c. County of Death 10:00 PM 2009 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Allegany Cumberland Memorial Hospital 8. Date of Birth (Month, Day, Year) Aug 10, 1942 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🔀 F 66 Director 219-56-7641 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f ahow any Injury or other traumetic evant, it is Medical Examinating the notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No **Allegany** MD Cresaptown Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 12914 Sixth Avenue Box 6 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Harrison Schramm Nita Billmyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Schoneberger/daughter P.O. Box 774 Ridgely. WV 26753 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature | Funeral Projectionse State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Party. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Myecardial Inturction Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Examiner ed by the attending physician and detached for use as the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by þ page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been s I or Attending Physician: The law efter death.

Director: After this certificate has 1 Yes 21 No 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours e 24 hours e 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and magner stated. To the within 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of pers th (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) legistrar's Signature State Registrar

DHMH 16 Rev 6/95

/Medical Examiner sicien end burial-transit The law requires that the death certificate be executed Division of Vital Records, P.b. Box 68760, ₹ this certificate has been signed by the ettending physicien ral director, page 2 should be detached for use as the burial To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

**Physician** 

/Medical

Examiner

10a, State

MD

Director

by Funerai

Completed

Be

Examiner

Physician/Medical

Be Completed by

Medical Certification; To

31. Date filed (Month, Day, Year)

FEB 0 2 2009

**Funeral** 

Director

or than "natural", or itema 23a or 28e-f show the Midlical Examiner must be notified at

the Maryland

death with

filed within 72 hours after

and Mental Hygiene.

permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if Item 27 is marked oth eny lighty or other treumatic even popel.

**Physician** 

or other treumatic event,

Baltimore, Maryland 21215-0036

Second contribution   2   Second contribution   2   Second contribution   2   Second contribution   2   Second contribution   3   Second contribut	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  d	
24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  25c. Was case referred to medical examiner?  1   Yes   2   No    25c. Vas case referred to medical examiner?  1   Yes   2   No    26c. Place of Death (Check only offe)  27c. Manner of Death  1   Natural   5   Pending investigation    28d. Date of Injury   28d. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only only only only only only only only	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	,
25. Was case referred to medical examiner?  1   Yes   20   No    26. Place of Death (Check only offe)  27. Manner of Death   1   Inpatient   2   ER/Outpatient   3   DOA    28. Date of Injury   28c. Injury at Work?   1   Yes   2   No    29a. Certifier (Check only only only only only only only only	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown
examiner?  1 Yes 21 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide  28a. Date of Injury At home, farm, street, factory, office  28b. Place of Injury At home, farm, street, factory, office  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe h			autopsy prior to completion of cause of death?
27. Manner of Death 15 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 1 Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred	examiner?	Hospitali	
29a. Certifier (Check only one)  29b. Signature and title of tertifier  29c. Place of Injury - At home, farm, street, factory, office 29d. Cattory, office 29d. Cattory, office 29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Sec. Injury at Work?  M 1 Yes 2 No	
(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of fertifier  29c. License number  29d. Date signed (Month, Day, Year)  Fig. 1007	dotomicod	289. Place of Injury - At home, farm, street, factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Theresto K- Impulation D 3066/ Thomas 15th 2009	(Check only 2 Medical Exen	iner: On the basis of examination and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated.  It is a stated at the time, date and place, and due to the cause(s)
30. Name and address of oberson who completed cause of death (Itemy 23a) (Type, Print Balling Balling - 16 21239	Deed to &	- Impueden D30661	Francous 15th 2009
Of Day Co. 1 (14 at Day Vend)	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print Club Blvd Ballimale Ball	inor- 16/21239

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, 6894, 8/31/U9, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wayne 2009 neg 054 /Medical 4c. County of Death

Wilcomics 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Salisbura Regional Med ICAI CENTE If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Age (In yrs. last birthday Social Security 0398 **Funeral** Months Days Hours Maryland Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting or must be modified at 1 ☐Yes 2 No **Funeral Director** alisbury Mary land COMICO 10f. Zip Code 10g. Citizen of What Country? 21801 Drive 15/0 1 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Worker Universi 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ar Pages 1 and 2 should ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) 19a. Informant's Name/Relationship permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other tran Drive Salisbury Mary and 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation Salisbury, Maryland 3 Removal from State Acres 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign our of Funeral Service Licensee 1.02 alven Wedhiltan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unique Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and a lee detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknowr 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 1 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat re and title of certifier D62107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 B. CARNULL St. SALISBURY, 100 € MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 2 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar 02543 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 Willie Robinson January 12:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3153 Queens Chapel Road #101 Mt. Rainer Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 71 Director 579-46-1381 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any hiury or other traumatic event. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2☐No Director Prince George's MDMt. Rainer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3153 Queens Chapel Road #101 20712 USA Funeral 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry un Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ٩ unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Prince George's Police Dept 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state 21. Signature of Funeral Service), icensee State Anatomy Board 655 W. Baltimore Street ,/Director Baltimore, MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eriose **Physician** eroTIC H disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burlal-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? certificate 1 ☐ Yes 1 □Yes 2 F1N0 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Registrar's Signatur 31. Date filed (Month, Day, State FEB 0 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** William Rufus Rich Jr. January 27 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Secu**tiv** Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Yrs. 05-26-1926 82 Director 214-20-352 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Exprehenment to notified at 1 ☐ Yes 2 ☐ No Director N/A Baltimore Md 10g. Citizen of What Country? 10e Street and Number Apt. 1202 Pages 1 and 2 should be filed within 72 hours after death with 21201 U.S.A Funeral Franklin St. 128 W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify:Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Callege (1-4or 5+) Truck Driver Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Brooks William Rufus Rich Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is 3014 Rockwood Ave. Balto. Md 21215 Jenifer Wayne Taylor Son Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 - 31 - 091 ☐ Burial 2☐ Cremation 3 ☐ Removal from State Greenmount Cemetery Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facilit Chatman-Harris Funeral Home 21. Signature of Euneral Service Liounger 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Days **Physician** rneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ere brovascular burial-transi Due to (or as a consequence of): Box 68760, physician a Physician/Medical ttending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 Ø No 2 🗆 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

e Funeral Director: A sletely filled in by the fi 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier elice, Medical Resident P23613 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Chalise

0 2 2009

31. Date filed (Month, Day, Year)

3. Registrar's Signature

900 Caton Ave, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav Year Emma Elizabeth 3:00 AM Reed 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care-Charles Street N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5-20-1935 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 218-48-3951 Director 73 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. Director 1X Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 E. 20th Street 21218 Funeral S Α 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XXIo þ Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry
Sales Represent 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Booker Nora Logan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1557 Waverly Apt E Nora Booker-Daughter Balto, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 2-3-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Carchrovasular in Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic groups (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 5 Other (specify) detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Mellitus Type 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsv After this certificate I perform 1 □Ýes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Sig<del>natu</del> 29d, Date signed (Month, Day, Year) 2201200 28/09 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

State Registrar

FEB 0 2 2009

Daljeet

31. Date filed (Month, Day, Year)

Saluja

32. Registrar's Signature

1. Aparts

ORIGINAL

Balt MD

36/2 talls Rd

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** anuan Joann Riidiger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖫 F 212-42-9559 May Director 64 10 1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unt. If unter the strain and the strain in the strain in the boardment any or other traumatic event, the Medical Econtinum rust boardment at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8008 Hadfield Court Funeral 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glendora ၉ Joseph Steinberg Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robin Coen 8008 Hadfield Court, Pasadena, MD 21122 Department of Health Important: If item 27 any Injury or other to once. (daughter) Date 30 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 Donation 5 Other (Specify) Metro Crematory Inc Baltimore, Maryland 21. Signature of Funeral Service Logn ce 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compil a ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e-cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ructive Pulmonary Examiner Obst NVONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown ils certificate has been s director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Riidiger

after death.

Director: Af
d in by the fur within 24 hours after
To the Funeral Directory

2

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital Drive, Glen Hame and address of person who completed cause of death (Item 23a) (Type, Print) icks

31. Date filed (Month, Day, State Registrar

32 Registrar's Signature Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 20 Month Year 200 BARBARA JAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MARYLAND MEDICAL RALTIMORE If Under 1 Year | If Under 24 Hrs. UNIVERSITY OF 5. Social Security Number CENTER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Apr 12, Days Months Min. 1 □ M 2 🛱 F 42 Apr Maryland 216-88-5620 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 11√ Yes 2 No Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 3301 Fall Cliff Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: white If Yes, Give "Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) salesperson automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Coleman Gloria Fidler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3301 Fall Cliff Road Baltimore, MD Scott Schenker/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State State Anatomy Board 655 W. Baltimore Street 21. Sign turn of Funeral Service & censee & Darector 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SYNDROME MELAS POSSIBLE disease or condition resulting in death) Due to (or as a consequence of): PNEUMON SEUDOMONAS Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 - Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown RESPIRATORY FAILURE ANOXIC BRAIN INJURY 24b. Were autopsy findings available prior to completion of cause of PNEUMONIA TOBACTOR PNEUMONIA performed death? 1 ☐ Yes 2 ☐ No MELLITUS 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 1 \( \text{Residence} \) 6 \( \text{Other} \) (Specify)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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Examine

Physician/Medical

2

Completed

Be (

Medical Certification: To

29a. Certifier

(Check only

filled in by

completely

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician be detached for use as the buria cate has been signal page 2 should b funeral director,

Division of Vital Records, P.O. Box 68760,

PSEUDOMONAS

and manner stated.

DIABETES 25. Was case referred to medical examiner? Hospital: 2 **N**0 1 ☐ Yes

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 🔲 Suicide

6 ☐ Could not be 4 🗌 Homicide

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

S

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

🛮 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

AU4176435617416

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIMBOLL 31. Date filed (Month, Day, Year)

OZUNE 32. Registrar's Signatur

Medi

State

Registrar

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day

Assistant Medical Examiner . Registrar's Signature arka resident

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

January 28, 2009

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician January 26 2009 /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 217-40-3408 4-6-1944 **Director** MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at XXYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ò death with 2709 Edison Avenue 21213 SA 23a Funeral items 2 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔀 No Black þ Specify: **X**Widowed 4 ☐ Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Homemaker Home 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Evans Rosa Bell Allen ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) If item 27 i 5932 Glennor Road Cynthia Allen -Daughter Balto, MD 21239 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or oth 2-2-2009 Balto Co, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East Balto, 1101 E. North Avenue MD 21202 andrae Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 100×10 /Medical s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 5012000 or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Day 5 Other (specify) 2 A 100 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes GALES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 138 2 No 1 Tyes certificate Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one æ Hospital: 1 🔲 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After the Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled the Hospital 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29b. Signature apd title of certifier 29c. License number 153368 anvery 28,2009

31. Date filed (Month, Day, Year) State Registrar

Peter

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

M.

Hill

Registrar

DHMH 17 Rev 1/2001 OCME 2006

State

OCME

2. Registrar's Signature

**ÓRIGINAL** 

31. Date filed (Month, Day, Year)

FEB 0 2 2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JANUARY 5:10 P M 29 2009 VIOLA M. SOPER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Sanctuary If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Aug. 12 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year) 1914 Maryland **Funeral** Months Days Hours 1 ☐ M 2 💢 F Yrs 94 218-56-3379 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show at 1 ☐ Yes 27 No ral", or items 23a or 28a-f sh Examiner must be notified Director WV Hampshire Romney 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 26757 HC 64 Box 2065 J.R. Rannells Road death Funera Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2XXNo f Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 【XNo Specify Baltimore, Maryland 21215-0036 nan "natural", c 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 5th Ø 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgie Knight Harry C. Poole ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HC 64 Box 2065, J.R. Rannells Rd, Romney, WV 26757 Shirley A. Palmer/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/1/2009 Burtonsville, MD Union Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 313 Talbott Avenue, Laurel, MD M01103 ancels 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Berrange **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed physician and stran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be det 2 1 | Yes 2 | No 3 | Probably 4 | Inknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: Hospital 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 TYes 2**5**€ No 1 🔲 Inpatient 2 this al or Attending Physical States death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) if Silverspring 9801 Georgia Avinu #1-17 Sunitha m D20902 Bho gavilli 82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Summers 29 0 verdean /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Sanctuary at Holy Cross Burtonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year NOV 21, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Country, I OWa 1 M 2 X X 1918 90 364-22-7068 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XX No Laurel Director Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20723 11217 Chaucers Ridge Court by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 XX X o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXIo Baltimore, Maryland 21215-0036 Specify: White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than Own Home 5+ Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be l and 2 should be fi lealth and Mental F Jennie Spoolman is marked Peter Van Beek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter Van Summers / son Department of Health a Important: If item 27 is any Injury or other tra once, Laurel, Maryland 20723 11217 Chaucers Ridge Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State West Arundel Crematory 1/30/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Donaldson Funeral Home, P.A. 20707 M00770 313 Talbott Avenue Laurel, Maryland Approximate Interval Between et and Death 23a. Part1. Enter the disease, shock, or heart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one-cause on each line. FREBROVASCULAR THEROSCHEROTIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II\_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by USPHAGT A 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has certificate has rector, page 2 1□ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier ruem

Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2009

VAINEEM

32. Registrar's Signature

2834

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SMITH

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JAN 28 **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 747-33-4/ Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No Director 66160 tt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No f Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: AS/A/ ò 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) E PAIR MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKIVOWN ၀ 19a. Informant's Name/Relationship (Type. Print) [9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARIT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State NORBECIC MEM PIL 31 JAN 09 4 □ Donation 5 □ Other (Specify) FUNERAL Home 21. Signature of Fiftheral Service License 22. Name and Address of Facility 110 LOCAL 10220 Coul Ford Rd. JESSUD, UND 23a. Part1. Early the disease, or complications that caused the dea in shock, or reart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Svage Dementie Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PARICINSONIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2010 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Suple MO 7AN 28 2009 D0053150

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 2 2009

DHMH 17 Rev 1/2001

ark

1021045

SHAKUNMACA GUPTA 9650 SANTIACO RD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amend #28c Per Phy G888 2/02/09 GH Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year JANUARY **Physician** SATTERWHITE DONALD WILLIAM 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year)

Peb 28, 1936 WASKIN Grow, D.C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. -48-3380 72 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Examiner must be routfled at 1 Nes 2 No MD. FREDERICK BRUNSWICK Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. or items 23a or USA OR CHARD LANE 21758 PEACH 1100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Specify: WHTE Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnetant of other. Elementary/Secondary (0-12) FARM College (1-4or 5+) ABOROR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABOTH WHITTAKER WILLIAM SATTERWITTE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIS) 19a. Informant's Name/Relationship (Type. Print) FREDERICK MD. 21703 5853 ROSEBAY CT HANSBURGER RUTH ANN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 60 SPEC COM. JAN 27, 2009 LISBON. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. Home 21. Signature of Funeral Service Licenses ollis 21701 Juny X. SOUTH ST PREDOCICE MO WCST Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause a each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** THE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed? 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ♣No 2 Accident 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM CARUE 195 John Thomas 62. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year VELNON SODEN 22 2000 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MARYLLOWS MED BACTIMOLE OF Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**XX**M 2□ F 57 MARYLAND 214-58-8625 JULY 13 1951 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County tXXYes 2 □ No MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 5005 CORLEY RD APT B7 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ∐Yes 2**XX**No Specify: Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UP TO DATE LAUNDRY LAUNDRY TECH 12th grade

18. Mother's Name (First, Middle, Maiden Surname)

Maryland 21217

20c. Location - City or Town, State

BALTIMORE, MARYLAND

Approximate Interval Between Onset and Death

unknown

2029 McCulloh St., Baltimore,

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1100ATT 75

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

32. Registrar's Signature

S GREENE

P

31. Date filed (Month, Day, Year)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

01-29-09

BALTIMORE

22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any highry or other traumatic event, the sonce. **Physician** /Medical

**Physician** 

/Medical

Examiner

10a State

17. Father's Name (First, Middle, Last)

Edith Soden/Wife

20a. Method of Disposition

Immediate Cause (Final

VERNON THOMAS SODEN

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Functar Solvio Licensee

19a. Informant's Name/Relationship (Type. Print)

1 ☐ Burial 2XXCremation 3 ☐ Removal from State

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Widdon Exercity and be notified at

Funeral Director

Completed by

Be

ပ

Examiner

attending physician and for use as the burial-tran signed by the a d be detached for page 2 should has After this funeral

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

Examiner Physician/Medical ğ Completed Be Certification: To To the Hospitar ... within 24 hours after death.
To the Funeral Director: Aft Medical

resulting in death)		1				
lesuring in deading	Due to (or as a conseq	uence of):				
Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	uence of):				
hat initiated events esulting in death) Last	Due to (or as a conseq	uence of):				
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	Il death 3 🗆 Ectopic			23d. Date of deliver Month D	y Day Year
Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the	cause of death?
				24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one		
examiner? 1 ☐ Yes 2 NNo	Hospital: 1 Inpatient 2 🗆	ER/Outpatient 3 ☐ [	OOA Other: 4 In Nursing	Home 5 Residence	6 ☐ Other (Specify)	
27. Manner of De th  1 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
29b. Signature and title of pertifier	Menu M		9c. License number	29d.	Date signed (Month, D	ay, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02556 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Salveson **Physician** Tarold 2009 523 AM anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barnnore Butimore VA Medical Center 8. Date of Birth (Month, Day, Year) Dec. 26,1932 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Days New Min. 072-24-1330 76 York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the wadical Examiner must be notified at 1 □Yes XXNo Dundalk Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3021 Liberty Pkwy. 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other traumatic event, the Medical Examinone. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korean 1 ☐ Yes 2 🔼 No Specify: Specify: δ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bally's Fitness Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Salesperson Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lydia Dryden Christian Adolf Salveson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 Liberty Pkwy. Mrs. Clara L. Salveson (Wife) Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ other (Specify) Service Corp. 2/3/2009 Towson, Maryland 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Axe. Dundalk, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia 1 WEEK /Medical Due to (or as a consequence of): **Examiner** · Yentratory-associated Respiratory failure 1 mointh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed atrial fibrillation with rapid vermicular vate unknown Due to (or as a consequence of) led by the attending physician detached for use as the burial Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by mortic valve stenusis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown obstructive Sleep apried 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate hypertension 2 🗆 No 1 □ Yes 2. No 25. Was case referred to medical examiner?

1 Yes 2 ANo Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation death. ours after death. 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar MO

Year)

Bernadette C. Suton MD

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

10 N greene Greet Baltzmure MD

1063547289

January 29. 2009

2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month SMITH 0020M LOUISA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSFICE RANDALLS TOWN BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2X F 98 38 3744 Director TOWA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MO BALTIMORE 1 Yes 2 □ No KESVILLE 10e. Street and Number 10g. Citizen of What Country? ō 23a TENTMILL LANE 21208 SA Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or ite. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify. 3 Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) IBRARIAN BOARD OF EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဨ CARSTENSEN KATIE KREBS 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert 2406 CHESTNUT TERR Baltimore, OUENTUN MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2/3/2009 PIKESVILLE, MO DRVIN RINGE CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility IN ZUM BOUN FIH & now CO SYFESVILLE POD ELDERS BURG MO 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner GANGRENE e to (or as a consequence of) RIGHT FOOT Sequentially list conditions, if any leading to improve cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed ACUTE ARTERIA OCCLUSION attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by cate has been signal page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate Vital 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ð After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

4

State

2835

Smith

Avenue sute

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Burton

32. Registrar's Signature

Lobarah

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 02558 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JÄNUARY BERNICE **SCHLOSS** 2009 10:22 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7902 BRYNMOR COURT. #401 BALTIMORE
If Under 1 Year | If Under 24 Hrs. BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** Days Hours 1 □ M XX F Director 86 MAR. 16. 1922 MD 217-16-4801 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director BALTIMORE MD **BALTIMORE** 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 7902 BRYNMOR COURT, #401 21208 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify WHITE à Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 8 . 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental SAMUEL ROSEMAN EVA KAMEROW 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is COURT, #401, BALTIMORE, MD 21208 HENRY SCHLOSS / HUSBAND 7902 BRYNMOR other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If it any Injury or or ö 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 01/30/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral/Service Chense SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 1 Yes 2 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has this certificate 2 □ No 1 □Yes 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Date filed (Month, Day, 32. Registrar's State FEB 0 2 2009 Registrar

DHMH 17 Rev 1/2001

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12		30. Name and address of person who	completed cause of c	leath (Iter	n 23a) (T			277	JA /	Ju /	1)21209
Sta	te	1 ASNEEM (Aik) 31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature/	ype, Print)  Mariant Harris	re sui	16 203	STOP	TCIO IL	1)010)
Registr		FEB 0 2 2009	Denews	A	gran	/Se/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear Month Day **Physician** 2000 XX /Medical Janvicke 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 **□**M 2 □ F 62 217-50-6398 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 DX es 2 □ No Director Perry III 10g. Citizen of What Country? 10e. Street and Number reen Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 Ak Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) nstaller Utilities 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ FIDRE lipton VIVAINIA Charles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) brer Valley Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gremition 21. Signatur 1 Funey L Service Licens 22. Name and Address of Facility 1232 Midvalle PA 18434 arch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each)line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) n signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No 217/No 1□ Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

DIVADAS

31. Date filed (Menth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 02561 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Frances Ruth Wolfe Januarv 2009 9:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Towson **Baltimore** 8. Date of Birth (Month, Day, Year)

July 12 1949 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 □ M 2 □ F 318-44-3353 Director  ${
m IL}$ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show les 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygiene.
If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, It we dien Examble in ust be notified at MD Director Prince George Adelphi 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9118 Riggs Road 20783 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No δ Specify Specify: white 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) restaurant server and manager 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kendra Lee Wolfe (daughter) 5378 Red Cedar Ct., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or o 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State All County Cremation | 1-31-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Sterwent P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER disease or condition resulting in death) LUNG /Medical Due to (ot w a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): O. Box 68760, pe Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2 No 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Xyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has t funeral director, page 2 s autopsy performed: 1 □Yes 2 No 2 □No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JANUARY 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIENE DOBERMAN, MD 6565 N CHARLES ST. 32 Registrar's Signature 31. Date filed (Menth, Day,-Year) --State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Min. 1 □ M 2 1 F Months Days Hours Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Exprise rinust be routiled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ₩ Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) (Friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12009 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2 W. North Ave. Inter the disease, or complications that could the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart dilure. List only one cause on each line. 23a. Pa / 1 Inter the J s shoot or heart / ilu Immedia e Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Physician 80 /Medical Due to (or as a conse vence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☑No Month Day Year 5 Other (specify) P.O. 9 Hlnknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ∏Yes 2 ∏No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate Vital 1 □ Yes After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

MD

29c. License number

D 31464

ENTAN St finte 300

29d. Date signed (Month, Day, Year)

BALTIMORE MD 2/241

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** bough ewton 2009 25 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kegiona Prince George aure Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) Min. 1 M 2 □ F Months Days Hours 769-56-821 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show 1 Nes 2 No traumatic event, the Medical Examiner must be notified Director aure 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9200 23a20708 Funeral items ; 12. Was Decedent Ever in U.S. Armed Porces? 1 Des 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □Yes 2 No Specify à Specify: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) U.S. Host Handler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Watkins Montgomer lova 19a. Informant's Name/Relationship ( pe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; if item 27 is any injury or other trau 9260 Van Fleet phine Watkins-WIte Laure 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State veterans: rownsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Limnsee 22. Name and Address of Facility uneral 20794 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory armst, Immediate Cause (Final MUCCARITAL Physician INFARCTION disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner HOREA TING-TOWS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Year Day 5 ☐ Other (specify) signed by the a Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, p 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ ⊌⊓known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe After this certificate of Vital 2 1 2 No 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 Inpatient 2 DER/Outpatient 3 □ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed caused death (Item 23a) (Type, Print) Laurel Regional Hospital irguieres, MD

State Registrar H

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

**ORIGINAL** 

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DONNELL , BROWN 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□ F Director 34 11/10/1974 214-84-4365 Maryland Usual Residence of Decedent t0a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov Director 11√2 Yes 2 □ No Calvert Lusby MD death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Wedical Eventiner must be 20657 USA 12671 San Angelo Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 □Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donnell Brown, Sr. Mildred Jacks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dameka Brown/Spouse 501 McElderry St.#304 Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Sunderland, MD Edmonds Cem. 1/19/09 22. Name and Address of Facility 21. Signature of Juneral Service Licensee Raymond-Wood F.H., P.A. 1 or PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
I.5 YEARS Immediate Cause (Final **Physician** REFRACTORY ACUTE MYELOGENOUS LEUKEMIA resulting in death) /Medical Due to (or as a consequence of): Examiner 3 WEEKS PNEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been si, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 W certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number DEA # 29d. Date signed (Month, Day, Year) AU4176435A 18283 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) à RW JANELL M. ALDEN 22 SOUTH GREENE ST. BALTIMORE MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 888 2-11-09 vt
State of Maryland / Department of Health and Mental Hygiene 02565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:32 A 2009 0. ALLEN 12, LARRY January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11/11/1951 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 X M 2 | F Yrs. Gary, WV Director 234-86-<del>3287</del> 57 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's Forestville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Items 23a United States 20747 3700 Walters Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Specify: Black 1 ☐ Yes 2 ☒ No Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Officer Private is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev ပ Eva Brown George Henry Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna B. Allen / Wife 3700 Walters Lane Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/16/2009 Landover, Maryland Harmony Memorial 22. Name and Address of Facility ope Funeral Homes, P.A. 21. Sign Aire of Funeral Service Liner see 4 01085 5538 Marlboro Pike Forestville, Maryland 20747 Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE IUMONAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner INCONTR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Examiner Due to (or as a consequence of): be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the t as IF FEMALE: use a 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 No 9 Unknown by signed to be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No √Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending investigation death, 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Tipertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

5 RO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day,

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٦	DI		Registrar  1. Decedent's Name (First, Middle, Last)		Commo	210 07 2	, cain	2. Date of Deatl		3. Time of Death
	Physicia /Medic	al	Kenneth Euge					01713		9:28A M
)	Examin	er	4a. Facility Name (If not institution, give street and 1760 Harvest Driv		4b. C		Location of Death erick		4c. County of De	
) .	Funeral Director		5. Social Security Number 225-32-3571 6. Sex	F 7. Age (In yrs. last to 78	oirthday) If Un Monti	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/8/1	Year)	irthplace (State or Foreign Country) VA
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location			27		10d. Inside City Limits
	e Mary a-f sho	ctor	MD Frederick		Fre	deric	k			TX∏Yes 2 □ No
	with the a or 28 be not	Director	10e. Street and Number 1760 Harvest Dr.		10f.	Zip Code		10	0g. Citizen of What 0	Country? USA
	ms 23g	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S.	13. Was De	2170 ecedent of His	J Z spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - An	nerican Indian,
220	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 1 1 1 If Yes	d Forces? ∕es 2∐ No s, Give or Dates:		specify Cubar s 2 <b>X</b> No	Specify:	Rican, etc.)	Black, Wh	
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, Mar	1 and 2 sho Health and em 27 Is ma		19a. Informant's Name/Relationship (Type. Print Marion Arnett (Wif	e)	1760 н	arves	t Dr.,		ick, MD	, Zip Code)
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משונוו	permit. Pages Department of Important: If it any injury or once.		21. Signature of Eureral Service Licensee		<sup>22</sup> Name Don	and Address	s of Facility om p	son Fu	neral Ho	
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	/Medical Examiner		resulting in death)	e to (or as a consequenc	e of):					
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ט. ססי	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	s, outcome pf pregnancy .ive birth 2 ☐ Fetal dea Pregnant at time of death Jnknown		c pregnancy (specify)			23d. Date of d Month	lelivery Day Year
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N II a	ian: T	a)	25. Was case referred to medical				26. Place of Dea	1 Yes 2 th (Check only on	7.	es 2 No
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5	th. :: After e funer	tion:	27. Manner of Death 28a. 1 Natural 5 Pending 2 Accident investigation	Date of Injury 28th (Month, Day Year)	o. Time of Injury M	28c. Injury Work 1 □ \	rat :? Yes 2 □ No	28d. Describe ho	ow injury occurred	
JIVISIOII OF	or Atter after dea Director in by the	Certification:		Place of injury - At home, building, etc. (Specify)	farm, street, fac	ctory, office		28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,
	Hospital	edical Ce	29a. Certifier 1 Certifying Physician: 7 (Check only one)	the basis of examination	lge, death occur and/or investiga	red at the tim	ne, date and place pinion, death occu	, and due to the ca	ause(s) and manner late and place, and d	as stated. lue to the cause(s)
	Fo the within 2 Fo the comple	Med	Oth Cignature and title of partition	manner stated.		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
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	(5)		30. Name and address of person who completed		a) (Type, Print)		C7			,
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			- State Registrar Amend# s27.29d		CI Ce	Tillicate of t	Dealli	2. Date of Dea	ath	000	3. Time of Death
	Physicia	_	DOROTHY BUTLER					1 / 4 / s	Day	Year	0648 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death			unty of Deatl	
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П	Funeral		5. Social Security Number 6. Se	1 M 2 🖼 F	last birthday) Yrs.	Months Days	Hours Min.	(Month, Da		Co	fax, NC
	Director	-	240-92-1326 Usual Residence of Decedent	56				12/5/	1952		
	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits  1 ▼ Yes 2 No
:	8a-f s	Director	Maryland Prince Ge	orge's Ca	apito1	Heights 10f. Zip Code			10a Citizer	n of What Co	
3	a or 2	Ö	10e. Street and Number  1011 Elfin Ave.			20743				d Stat	
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326	be flied within 72 hours after death with the Maryland and Hylgiene. All Hylgiene and other than "natural", or items 23a or 28a-f show event, the Modical Evaning must be motified at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	o moun, order		pecify: B1	
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7	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):		N	59.			
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9 X0	eath certiffi attending p for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi		☐ Ectopic pregnan	CV		23	d. Date of de	livery Day Year
P.O. Box	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)	7			Month	Day Teal
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V Its	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?  1 Yes 2 □ No	Hospital: 1 Inpatient 2[		ent 3 🗆 DOA Ot	her:	eath (Check only Home 5 Res		Other (Sp	acify)
oţ	g Physer this eral di	n: To	27. Mannet of Death	28a. Date of Injury (Month, Day, Year)	28b. Time			28d. Describe			Fell at
ion	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending investigation	December 23	2008	M 1 [	∐Yes 2⊒1¶o 	hom-			
ivis	or Atter de Directe in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - Atbuilding, etc. (Spec	cify)	street, factory, office		28t. Location City or To	wn. State)	Number or H	Jural Poyte Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		(Check only 2 Medical Exar	ysician: To the best of my k niner: On the basis of exami	nowledge de	ath occurred at the	time, date and pla opinion, death oc	ce, and due to th	e cause(s) a	and manner a place, and du	as stated /U/Ar / Excellent to the cause(s)
	thin 2, the formula the formul	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date	signed (Mon	oth, Day, Year)
	ΗSFŏ		100	1/1-		2	2053	103	Jani	4/4/	5, 2009
	10		30. Name and address of pers who	completed cause of death (It	em 23a) (Typ	e, Print)	11/2 11/2	und.	MA	77.70	5
N	_10		De Sein Der	have 5001	HUSD	the Dr	ive in	very	vec)	AU 780	J
	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	alle	,					

		-	State of Maryland /  State of Maryland / Registrar	Department of H			giene , Reg. No. <sup>(</sup>	2009	02568
X	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Day	Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	MANUEL	4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 578-22-1238 PM 2 F 83	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da JULY 2	th	9. Birth Cou	place (State or Foreign intry) DC
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location					10d. Inside City Limits
	Maryli a-f sho	tor	DC	WASHING	STON				i¥∐¥Yes 2 □ No
	with the 3a or 28a st be not	I Director	10e. Street and Number 2226 SHEPHERD STREET N.E.	10f. Zip Code	20018		10g. Citize	U.S.A.	1
220	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inimportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  12. Wes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2₩No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		4. Race - Ameri Black, White Specify: BI	
7-617	thin 72 hou e. an "natura Medical E	Completed	(Specify only highest grade completed)	6a. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	during most of work f) -			d of Business/Ir	
7	led wit lygien her tha nt, the			INANCE CHIEF	18. Mother's Nam				MINISTRATION
מ	d be fii ental H ked otl c ever	To Be	17. Father's Name (First, Middle, Last)  JAMES BAILEY		SYLVIA		BUCKL		
ary	shoul and Me smark	F	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street a	and Number or Ru	ral Route Numb	er, City or	Town, State, Zi	ip Code)
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	Pages 1 ment of H tant: If Ite jury or ot		1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State QUANT	e of Disposition (Name of etery, crematory or other place CICO NATIONAL	01-2	1-2009	TRIAN	GLE, VI	RGINIA
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, i	Physician and /Medical Examiner sthe paral-transit	ical Examiner	Sequentially list conditions, if any, reading Cause (Disease or injury that initiated events resulting in death) Last  Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) Due to (or as a consequence of	ce of):	nom Moto	ir Veh	vele.	Accido	Onset and Death
C. Box 6	ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal der 4 □ Pregnant at time of death	eath 3 ☐ Ectopic pregnancy	y		23	3d. Date of deli Month	very Day Year
<u> </u>	es that gned b	by Pt	Part II. Other significant conditions contributing to death but not resulting to death but not resulti	g in the underlying cause giv	ren in Part I.				the cause of death?
Records,	ne law requires that the do s has been signed by the ge 2 should be detached	Completed	CATAIAC TITTAY TONGITTS			24a. Was auto perf	opsy ormed?	24b. Were au prior to death?	topsy findings available completion of cause of
_		Be Co	25. Was case referred to medical		26. Place of Dea	1□ Yes th (Check only	one)	1 □ Yes	2 No
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Division or	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely illied in by the funeral director.	Certification:	1 Natural 5 Pending (Month, Day Year)  Accident investigation 7 Process & Zeos 1  Suicide 6 Could not be determined element of the part of		ry at rk?  Yes 2⊠No	28f. Location City or To	(Street and own, State)	Twill Number or Ru	ural Route Number,
	e Hospital 24 hours e Funeral etely filled	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle part of the desired from the past of examination and manner stated.			e, and due to the	e cause(s)	and manner as	tated.
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S	26		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23 Salvador Sal	Ba) (Type, Print) pital Drive	e, ch	velle	Ma	yland	
	St Regist	ate trar	31. Date filed (Month, Day, Vear) 32. Registrar's Signature 1. A.N. 1 R 2009	9		01	(		

		-	For State Registrar		State of Ma	ıryland		artment of rtificate of			/lental H	ygien Reg. N		9 02	569
	Dhusisi			ne (First, Middle, La	st)						2. Date of I	Death	ay Yea	3. Time o	of Death
	Physicia /Medic		Stewart	L. Bake								ary	13, 20	09 12:3	85 p <sup>M</sup>
	Examin	er			e street and number)	-77 Foot	11	4b. City, Town,			m.~	ŀ	c. County of De		
	Funeral		5. Social Security N	Number 6. S		(In yrs. las		If Under 1 Year Months Days	If Un	r Spri der 24 Hrs. rs Min.	8. Date of E (Month,			George ' Birthplace (State Country)	
	Director		577-12-0	0138	M 2□F	8	88 Yrs.	Wioritis Days	1100	IS WIIII.	Aug. 1	17, 1	920 Was	shingtor	, DC
land	Mo #		Usual Residence of 10a. State	10b. County		10c. City,	Town or Lo	cation		<u> </u>				10d. Inside 0	City Limits
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/ith th	or 28	Director	10e. Street and Nu					10f. Zip Code					itizen of What	Country?	
eath v	ns 238	Funeral	3124 G	racefield	Road, Apt			Was Decedent of	209		ecify Yes or I		JSA 14. Bace - Ar	merican Indian,	
d 2 1 2 1 3 0000 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shot other traumatic event, the Medical Evarianer must be notified at	by Fun		ried 2 🛣 Married 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates: 1	lo		Was Decedent of If Yes, specify Cu 1 □Yes 2 ☑ No			Rican, etc.)		Black, Wi	nite, etc.	
2 hou	natura iical E		(Sna	15. Decedent's E	ducation		16a. Dece	dent's Usual Occ	upation	most of work	ina	16b.	Kind of Busines		
ithin 7	han "r	Completed	Elementary/Seco		College (1-4or 5-	+)		kind of work don DO NOT use retir		nost of work	ing				
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ild be	and Mental Hygiene. is marked other thar aumatic event, the M	To Be		t Lee Bak							e Earl		ŕ		
2 should	and N is mai			lame/Relationship	21 /			ng Address (Stree				-			2090
and	tealth im 27 her tr			Baker/Wif	e	Took Die		Gracef	ield	1					, MD
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permit.	Depart mport iny inj ince.		21. Signature of F	uneral Service Lice	nsee ()		22 F	Name and Add				al H	ome Ind		
	= 1.0 G		23a, Part 1, Enter	the disease, or com	plications that caused	the death.		00 Unive					er Spri	Approxima	ite
1	ysician Medical aminer	er	Immediate Cause disease or conditi resulting in death)	(Final on	one chuse on each lin  a Cerebrova  Due to (or as a	scula conseque	nce of):	cident						Interval Be Onset and	Death
ificate be executed	physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate natural finds the first underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.												
or Attending Physician: The law requires that the death certific	attending for use a	sician/M	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	2 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal d	eath 3	☐ Ectopic pregnal ☐ Other <i>(specify)</i>				-	23d. Date of o	delivery Day	Year
uires that	signed by the and be a second to the and the a	d by Phy	Part II. Other sign	ificant conditions	contributing to death bu	t not resulti	ng in the u	nderlying cause g	iven in Pa	art I.				to the cause of	
he law req	te has been s age 2 should	Completed									pe	topsy rformed?	prior f death		available cause of
ian:	ertifica ctor, p	Be C	25. Was case refe examiner?	rred to medical					26. P	lace of Deat	1 ∟ Yes h (Check only	2 <b>X</b> N (one)	10 1 11	es 2□No	
Physic	er death. rector: After this certificate h. by the funeral director, page	၉	1 Yes 2x 27. Manner of Dea		28a. Date of Injur	y 2	8b. Time of	IL 3 LI DOA		Nursing Ho	ome 5 Re		6 ☐ Other (S	pecify)	
	ath. r: Afte ie fune	atior	1 X Natural 2 ☐ Accident	5 ☐ Pending investigatio	(Month, Day	(, Year)	Injury		ork? ⊒Yes 2	2□No					
al or Atte	s after de	Certification:	3 ☐ Suicide 4 ☐ Homicide	6		ry - At hom . (Specify)	e, farm, str	eet, factory, office			28f. Location City or T	_(Street a own, Sta	and Number or te)	Rural Route Nur	mber,
he Hospit	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)		nysician: To the best of miner: On the basis of and manner sta	examinatio									s)
To t	N P P P P	P	29b. Signature	title of certifier	deals,	10		29c. Licei d	nse numb 36 <b>71</b> 6					nth, Day, Year) .3, 2009	
	,			ress of person who Kundrat,	completed cause of de MD 3110 G			Print) Road, S:	i <b>1</b> ve:	r Spri	ng, MD	209	04		
	Sta Registr		31. Date filed (Mor	nth, Day, Year)	32. Registra	r's Signatur	re	23							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 1824 2009 5:39 A M BORGESE HARRY J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL ELKTON UNION HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 X M 2 □ F 1922 164 12 9508 Director JUNE 10. PA 86 Usual Residence of Decedent 10b. County CECIL 10c. City, Town or Location ELKTON 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21921 26 BRIDGEWELL PARKWAY Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1941 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married WHITE 1 ☐ Yes 2 🛛 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "in any Injury or other traumatic event, the Meating ODICE. Elementary/Secondary (0-12) College (1-4or 5+) BAR/TAVERN OWNER/OPERATOR 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NINA BOTTINO JOHN BORGESE ပ္ 19a. Informant's Name/Relationship (Type. Print) ANN MARIE BURKETT- DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $159\ 4\text{TH}\ \text{AVENUE},\ \text{ASTON},\ \text{PA}\ 19014$ 20b. Place of Disposition (Name of SS PETER & PAUL 20c. Location - City or Town, State JAN 23, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 CEMETERY SPRINGFIELD, PA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility HOMES PO BOX 2866, WILMINGTON DE 19805 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ocardin /Medical Due to (or s a consequence of) Examiner petasin if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Month Year 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 KER/Outpatient 3 □ DOA 1∐ Yes 2XNo 1 🔲 Inpatient Certification: To 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

that the death certificate be executed sician and burial-trans O. Box 68760. the. attending p page 2 should has Division of Vital After this certification, I Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

filed within 72 hours after death

"natural".

Baltimore, Maryland 21215-0036

Medical

State Registrar 4 Homicide

Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bow

Brian GRoces 31. Date filed (Month, Day, Year.

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12, 2009 **Physician** Sarah Booth Conroy 7:55A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Manor Care Health Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 16, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🙀 F 255-34-3354 81 Georgia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Montgomery Director Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9011 1st. Avenue 20910 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify. þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mentał Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) the Journalist Newspaper traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weston Anthony Booth Ruth Proctor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 9011 1st. Avenue Silver Spring, Maryland 20910 Richard T. Conroy -husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State Metropolitan Crematory 1/12/2009 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Bonald VieBorgWardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Multiple Dicubitus Ulcers Sequentially list conditions any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Dementia use as the burial-trail Due to (or as a consequence of) attending physician Completed by Physician/Medical Anaemia IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform **≱**□ No 1 ☐ Yes : After this certifica e funeral director, r Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed or Vital Records, P.O. Box 68760, Division or Attending hours after death. Ineral Director: Af y filled in by the fu

Baltimore, Maryland 21215-0036

6 ☐ Could not be

3 Suicide determined 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) D20274 December 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kirti Vohra, M.D. 7710 Bradley Blvd. Bethesda, Maryland

State Registrar 31. Date filed (Month, Day, Year) 15 2009



within 24 hours a

to the Funeral I

completely filled To the Hospitai

Medical

29a. Certifier

		For State Registrar				tificate of		d Mental H	Reg. No	2009	
Physicia /Medica		Decedent's Name (First, Middle,  Jung	I Ja Chung	İ				2. Date of D Month <b>Janua</b>	Da	y 2009	3. Time of Death <b>5:10 a</b> M
Examine Funeral Director	er	4a. Facility Name (If not institution, Randolph Hills No. 5. Social Security Number 218-41-0952	lursing Ho		est birthday) Yrs.	4b. City, Town, of Silver. If Under 1 Year Months Days	Spring	eath	irth	Montgom  9. Birth	
D	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Hou	vard		Town or Loc		Clarks				10d. Inside City Limits 1
ath with the 23a or 2		10e. Street and Number 7121 Chilton	1			10f. Zip Code	21029			tizen of What Cou	.A.
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Evantinat must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	d 12. Was Deceded Armed Force 1 □ Yes 2 If Yes, Give Ye ar or Date	es? M⊠No		Vas Decedent of fyes, specify Cub		? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Ameri Black, White, Specify:	
within 72 hours after death with the Marylan jiene. r than "natural", or Items 23a or 28a-f show the Medical Evantinet must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4-	or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Homemo	during most of od)	working	16b. K	Cind of Business/In	•
othe rent,	To Be Co	17. Father's Name (First, Middle, La	-			HUMCHO	1	Name (First, Midd	e, Maider		· VIIIC
and 2 should be alth and Menta 127 is marked er traumatic ever		19a. Informant's Name/Relationship Heasook Kwon -								or Town, State, Zi	
permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate ce	metery, cren	sition (Name of natory or other pla Ln Cremo		Date /16/2009	1	ocation - City or To	
permit. Departitimport		21. Signature of Funeral Service Li	censee T. Wobai	1	Hi 11	Name and Addr Nes-Rind 800 New	ess of Facility Udi Fun Hampshi	eral Hom re Ave.,	e. II Sil	nc. ver Spri	ng, MD 2090
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attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		th 2 Fetal nt at time of de	death 3	Ectopic pregnan	су			23d. Date of deliv	very Day Year
res ti	<u>۾</u>	Part II. Other significant condition	s contributing to deat	th but not resul	ting in the ur	nderlying cause gi	ven in Part I.				the cause of death? bably 4 🔀 Unknown
aw 2 sl	Completed	25. Was case referred to medical						pe 1 □ Yes	opsy formed? 2 <b>X</b> No	prior to co	opsy findings available ompletion of cause of 2  No
nyslci nis cer direct	ertification: To Be	examiner?  1 Yes 2 12 No  27. Manner of Death  1 12 Natural 5 Pending  2 Accident investiga  3 Suicide 6 Could no	28a. Date of (Month,	Day, Year)	28b. Time of Injury	28c. Inju	her: 4 🗶 Nursir	28d. Describ	sidence e how inju		
pital or Ai ours frer c eral oirec filled in by	O	4 ☐ Homicide determin	ed   20e. Place of	, etc. (Specify,	) 	eet, factory, office	time, date and n	City or 7	own, Stat		
To the Hospital or Attending Pl within 24 hours. Iter death. To the Funeral Director. Afferti Completely filled in by the funeral	Medical		xaminer: On the bas and manne	sis of examinati		vestigation, in my			e, date an		to the cause(s)
5		30. Name and address of person w					D52261			anuary 1	4, 2009
Stat Registra		Alan R. Segal 31. Date filed (Month, Day, Year)	32a Rec	517 Hug gistrar's Signati	ire		ver Spr	eng, Mari	jkand	1 20906	

DHMH 17 Rev 1/2001

		For State Registrar	State of	Maryland		artment <i>rtificate</i>			Mental Hyg	giene Reg. No 20	09	025	73
Physic /Modi		Decedent's Name (First, Middle	e, Last) Arthur Alfre	d Checchi	Ĺ				2. Date of Dea	14 20	Year	3. Time of 1	
/Medi Exami		4a. Facility Name (If not institution				4b. City, To	wn, or Loc	ation of Death		4c. County			
A <sup>2</sup>		3154 Gracefield 5. Social Security Number		r Glen 3		If Under 1		r Spring Under 24 Hrs.	8. Date of Birt			eorge's	r Foreign
Funeral Director		004-18-2784	152 M 2□F	. Age (117 y 13. 12	Yrs.			ours Min.	(Month, Day	/, Year)	Cou	place (State or ntry) <b>Maine</b>	roreign
פ		Usual Residence of Decedent							nagast 1	3, 1322			
arylar show	<u>_</u>	10a. State 10b. County		10c. City,	, Town or Lo	ecation					1	l0d. Inside City 1 ☐ Yes	
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with with a or		3154 Gracefield	Dood Homes	- Cla- 2	11	101. ZIP C		20001		rog. Gilizeri oi v		•	
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or ite		1 ☐ Never Married 2 🙀 Marr	ied Armed Forc 1 ☐ Yes 2 If Yes, Give	. No		If Yes, specify 1 □ Yes 25		lexican, Puert pecify:	o Rican, etc.)		ck, White,	etc.	
"natural", or	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:						Specify	W	hite	
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and ZIZID-UU30  I be filed within 72 hours after death with the Marylan antal Hygiene.  Red other than "natural", or Items 23a or 28a-f show to event, the Medical Examinar must be notified at	BeC	17. Father's Name (First, Middle,		·					ne (First, Middle,				
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IOCE, INIARYIS ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (S	treet and	Number or Ru	ral Route Numbe	r, City or Town,	State, Zij	Code)	
e, IV 1 and 2 Health Pm 27 sm 27 ther tra		Josephine A. Chec	cchi – Spouse		1			ad-Hunte	r Glen 31			<u> </u>	20904
ages 1 nt of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		ate 200. Pi	ace of Dispo emetery, crei	sition (Name matory or othe	or r place)	6 1 8	Date	20c. Location -	City or 10	own, State	
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		23a. Part 1. Enter the disease, or	complications that cau	used the death.			-		enue, Silv or respiratory ar		g, mar	Approximate Interval Betw	
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/Medical		resulting in death)		r as a consequi							_		
Examiner		Sequentially list conditions,	U.	t Failur		rive							
ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca	Due to (or	r as a conseque	ence of):						-		
execu	xar	that initiated events resulting in death) Last	c Due to (or	r as a conseque	ence of):						-		
of ou, cate be executed physician and the burial-transit	cal	d.											
oo/ rtificate ng phys as the	Medi	d.											
I HECORDS, P.O. BOX OR The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregnar		☐ Ectopic pre	nancy				te of deliv	,	4
the a	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unknov	ant at time of de wn	eath 5	Other (spec	ify)			IVIO	onth	Day Yo	ear
w requires that the dospension signed by the should be detached		Part II. Other significant condition	ons contributing to dea	th but not resul	Itina in the u	nderlying cau	se given in	Part I.	23e. Did to	bacco use cont	ribute to t	he cause of de	eath?
COTOS, w requires to been signer should be considered.	d by		Ü			, ,	3			es 2 😿 No			
w red	Completed								24a. Was	an 24b. V	Were auto	ppsy findings a	vailable
The law	mo								autop perfo	med?	prior to co death?	mpletion of ca	
VITAI Ilcian: T certifica ector, pi	a l	25. Was case referred to medical					26.	. Place of Dea	1 ☐ Yes th (Check only o		1∐Yes	2 🗆 No	
OT V Physic r this ce	To B	examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 ☐ In	patient 2 🗆 E	ER/Outpatie	nt 3 DOA	Other: 2	↓ □ Nursing H	ome 5 🗷 Resid	lence 6 Oth	er (Speci	fy)	
Ing P	ü.	27. Manner of Death 1   Natural 5 □ Pendin	g 28a. Date of (Month)	Injury , Day, Year)	28b. Time o Injury	1	Injury at Work?	_	28d. Describe h	ow injury occurr	red		
VISION  Attending or death. ector: After by the fune	icati	2 Accident investion 3 Suicide 6 Could	not be	f Injury At hor	ma farm at	M Cost fastenia		2 □ No	OOA Leastion (				
lor A after Direc	Certification:	4 ☐ Homicide determ	nined 28e. Flace o	f Injury - At hor g, etc. <i>(Specify</i>	)	eet, lactory, o	rice		28f. Location (8 City or Tow	n, State)	er or Hura	ai Houte Numb	er,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s			ng Physician: To the b Examiner: On the bas										
the H	Medical	one)	and manne	er stated.								``	
P ≥ ≥ 0	-	29b. Signature and title of certifier	Pu thum	0 1 4	MD	290. 1	icense nu			29d. Date signe			
S		30. Name and address of person			23a) (Time	Print)	D59	<b>524</b>		Januar	гу 14,	2009	
		Loveen J. Puth				·	Silver	Spring.	Maryland	20904			
	ate	31 Date filed (Month Day Year)	20 Rec	nistrar's Signati	ure								
Regist	rar	JAN 15 2	2009 Sente	w B.	19an	Ken							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 02574 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** George Louis Chapman, Jr. 1630 JANI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 11284 Laurel Walk Drive Laurel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 1 M 2 ☐ F 8. Date of Birth **Funeral** Months Days Hours Min May 19, 1930 78 Massachusetts **Director** 577-36-7210 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Prince George's Laurel 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 11284 Laurel Walk Drive 20708 United States Items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S.
Anned Forces?
1 £1 Yes 2 □ No
If Yes, Give 1951-1975 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 0 1 ☐Yes 2XNo White Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. d other than "; Elementary/Secondary (9-12) College (1-4or 5+) U.S. Post Office Special Delivery Messenger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Helen Kilcovne George Chapman, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Stubble Field Way Silver Spring, Maryland 20905 Brian J. Chapman -son 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Arlington National Cemetery 1/27/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Jonald V. Borgwardt Funeral Home. PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ğ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
22 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records, ours after death neral Director: / filled in by the f To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

10+1 State

31. Date filed (Month, Day, Year 5 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Modical Examinat must be notified at any injury or other traumatic event, the Modical Examinat must be notified at any once.

**Physician** 

/Medical

Examiner

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylend

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

To the Hospital or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	070-64-2	2750	1 🗆	M 2∑∑ F	93	Yı	Mont	hs Days	Hours	Min.	MAY 3	ay, Year 19	)	Country) GUYANA
	Usual Residence of	Decedent							-			,		
	10a. State	10b. County			10c.	City, Town	or Location							10d. Inside City Limits
ctor	MD.	PRINCE	GE(	ORGES			RIV	ERDAL	E					1X Yes 2 □ No
흘	10e. Street and Nur	mber					10f.	Zip Code				10g. C	tizen of What	Country?
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nei	11. Marital Status		1	Armed	ecedent Ever in Forces?	U.S.	13. Was De If Yes,	specify Cub	lispanic O an, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	10-	14. Race - A Black, W	merican Indian, hite, etc.
Ž F	1 ☐ Never Marri 3 ☐ Widowed	_			s 21∕∏ No Give	j	1 □ Ye	s 2X No	Specify	<i>y</i> :			Specify:	2
ğ D	SAL Widowed	15. Deceder	- 1		r Dates:	1 40- 5						1 401 1		BLACK
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Be Completed by Funeral Director	Elementary/Seco	ndary (0-12)		College 1	(1-4or 5+)			MEMAK					HOME	:
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To B	WI	LFRED			DAVIS					CAT	HERINE	(	CENDREC	OURT
	19a. Informant's Na	ame/Relations	ship (Typ	e, Print)		19b. !	Mailing Add	ess (Stree	and Numl		ral Route Numi			
	JOHN	CASEY/	SON			11	30 LI	NDEN	AVE.	ТАК	OMA PAR	SK I	m 209	12
	20a. Method of Disp	position				. Place of D	Disposition (	Name of			Date	-		or Town, State
	1 □ Burial 2 [ 4 □ Donation			emoval fro		-	RS CR		1	1-14	-2009	R]	VERDAL	E. MD.
	21. Signature of Fu	neral Service					22. Name	and Addr	ss of Faci	lity II	OME & C			
	10/1	W. C.	Mu	Mly	ull M	100091	5801	CLEV	ELAND	AVE	., RIVE	ERDAL	E, MD.	20737
	23a. Part1. Enter the shock, or hea	he disease, or rt failure. List	complic	cations that									- The State II Walle	Approximate Interval Between
	Immediate Cause (	(Final	,											Onnet and Death
	resulting in death)		C a	Due	to (or as a cons	equence of	):			, ,		5.8		1420 71 1161
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cam	Cause (Disease or that initiated events resulting in death) I	injurý S Last	c.		. ,									
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de			, d.											
Me	IF FEMALE:		25	a lives	outcome of pro-	22.00.01								
an	23b. Was decedent in the past 12	months?	20	1□Liv	outcome of precedents	etal death		c pregnanc	у				23d. Date of a Month	delivery Day Year
ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			9□Un	egnant at time o known	r death	5 Other	(specify) _						,
님	Part II. Other signif	icant conditi	ons con	tributing to	death but not r	esulting in t	he undertvir	o cause o	en in Part	1.	23e. Did	tobacco	use contribute	to the cause of death?
Due to (or as a consequence of):														
ete											24a. Wa		24h Wasa	autonou findingo available
Comp		-										opsy formed?	prior death	autopsy findings available to completion of cause of ?
င္ပ	25. Was case refer	rod to modice									1 ☐ Yes	2 - N	1 U Y	es 2□No
∞	examiner?			ospital: _ ,		Π.Ε.Β.(O.)		Ot			th Check only			
<u>۲</u>	27. Manner of Deat		_	28a. Da	te of Injury	☐ ER/Outp 28b. Tir		DOA	461	lursing Ho	ome 5 ☐ Res 28d. Describe	_		pecify)
틸	1 ☑Natural 2 ☐ Accident	5 ☐ Pendii investi		(M	onth, Day Year,		ury M	28c. Inju Wo	rk? Yes 2.[	1No	200. Describe	now and	ny occumed	
fica	3 🗀 Suicide	6 ☐ Could	not be	28e. Pla	ce of Injury - A	t home, farn					28f. Location	(Street a	nd Number or	Rural Route Number.
determined determined determined building, etc. (Specify)														
S S	29a. Certifier	12 Certifyin	ng Phys	ician: To	the heat of my h	rndwiedae	dieth unoir	red at the h	me data s	nd place	and due to the	a causale	d and manner	as states.
Medical Certification;	(Check only one)	2 Medical	Examin	er: On the	basis of exam anner stated.	ination and/	or investiga	tion, in my	pinion, de	ath occur	red at the time	, date an	d place, and o	lue to the cause(s)
Me	29b. Signature and	title of certifie	or .					29c. Licen	se number		1	29d. Da	ate signed (Mo	onth, Day, Year)

State Registrar A. DEVORE

31. Date filed (Month, Day, Year)

01852

oceashory Rd Hyatteville Mis 2018

JANUARY 14 2009

#### Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BARBARA ANN CLEMENTS PHUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) CHARLES ATCIVI. CENTER DICAL Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2\CX Months Days **Director** NOV.29,1938 217-42-3362 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f sho Director MD CHARLES WALDORF 10f. Zip Code 10e. Street and Number 6224 WOLVERINE PLACE 20603 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DATA ENTRY OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM EMORY DOVE P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN P. CLEMENTS/SPOUSE 6224 WOLVERINE PLACE WALDORF, MARYLAND permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JANUARY 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 28,2009 METRO . CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Funeral Service License M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause of Unsease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): physiclan s the buria Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the atter I be detached for u 3 Ectopic pregnancy 5 ☐ Other (specify) Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Records, Completed by failule, 24a. Was an performed certificate 1895 05051 1 ☐ Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 7 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Division 5 ☐ Pending investigation 1 PNatural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

R. Sindhuml

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> WASHINGTON, DO 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U. S. A. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry DATA ENTRY BUSINESS CORINNE MONTGOMERY KLOTZ 20603 20c. Location - City or Town, State ALEXANDRIA, VA Approximate Interval Between Onset and Death day 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 honknown 24b. Were autopsy findings available prior to completion of cause of death? 2 40 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suite 101 Waldorf, MD 20602

Birthplace (State or Foreign Country)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

6 Post Office Rd

Registrar
DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		,	rtificate of		Reg.	No.2009	02578
	Physicia		1. Decedent's Name (First, Midd Evelyn Phyllis					Date of Death Month January	Day 15 2009	3. Time of Death 7:50 A M
	/Medic Examin		4a. Facility Name (If not instituti Berlin Nursing			4b. City, Town, o	r Location of Death		4c. County of Death	
-	Funeral Director		5. Social Security Number 154-20-6481		e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. 8	Date of Birth		place (State or Foreign intry)
	land ow		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary 8a-f sh	ctor		ester	Ocean Pi					1 □Yes 2 No
	h with th	al Dire	17 Brookside	Road		10f. Zip Code 21811		-	. Citizen of What Cou SA	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventinar must be mailted at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 🕻 Ma 3 □ Widowed 4 □ Divorce	If Yes, Give A	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White, Specify: Whi	etc.
15-0	n 72 ho "natur edical	Completed by	(Specify only high	ent's Education nest grade completed)	(Give	edent's Usual Occup kind of work done DO NOT use retired	pation during most of working d)	16	b. Kind of Business/Ir	ndustry
212	od withii /giene. er than t, the M	Comp	Elementary/Secondary (0-12)	College (1-4or 5	)+)	ister Nur	se	N	ursing	
and	ld be file lental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle Elias L. Coste				18. Mother's Name ( Josephine		den Surname)	
Baltimore, Maryland 21215-0036	and 2 shou salth and M n 27 is mar er traumat		19a. Informant's Name/Relation Robert Davis	nship <i>(Type, Print)</i> Husband			and Number or Rural Road, Ocea			
imore	Pages 1 at the ment of He tant: If item			n 3 □ Removal from State (Specify)	Cape Henl	matory or other place lopen Crer	n. $1/17/2$		c. Location - City or T rankford,	
Bai	Depart Import any In		21. Signature of Funeral Service	ce Licensee		2. Name and Addre	ss of Facility Bur am St., Ber	bage Fur lin, MD	neral Home 21811	·
ag.	Physician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	ist only one cause on e. ch li a.	I the death. Do not en ne.  A A A A A A A A A A A A A A A A A A A	11	ng, such as cardiac or			Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b but to (or as	a consequence of y.					
68760,	icate be executed physician and the burial-transit	Medical Ex	resulting in death) Last	Due to (or as	a consequence of):					
P.O. Box 6	ath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √0 o 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	sy	_	23d. Date of deliver Month	very Day Year
	n requires that the de been signed by the should be detached	d by Ph	Part II. Other significant condi	itions contributing to death b	A 4	underlying cause giv	en in Part I.		cco use contribute to	the cause of death?
l Reco	The law recate has bee page 2 short	Completed by						24a. Was an autopsy performer	d?   death?	opsy findings available ompletion of cause of
Vita	slcian: The certificate rector, pag	a	25. Was case referred to medic examiner?	Hospital:		oth	26. Place of Death (	Check only one)		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, it	Certification: To	3 ☐ Suicide 6 ☐ Could	28a. Date of Inju (Month, Date of Inju (stigation)	ent 2 ER/Outpatie  ury y, Year)  28b. Time of Injury  ury - At home, farm, st	of 28c. Injur Wor M 1	ry at k?  Yes 2 No	d. Describe how	ee 6 Other (Specinjury occurred et and Number or Rui	
<u>≥</u>	spitat or A		29a. Certifier 1 Certify	building, et ying Physician: To the best	c. (Specify) of my knowledge, dea	th occurred at the ti	me, date and place, ar	City or Town, S	State) se(s) and manner as	stated.
	the Ho hin 24 I the Fu mpletely	Medical	one)	al Examiner: On the basis of and manner st		nvestigation, in my o			and place, and due . Date signed (Month	
	<b>6</b> ½ <b>6</b> 0		29b. Signature and title of certif	MMT	111	-	-605/5	290	11609	, 24, 1041)
	BAID		30. Name and address of person	on who completed cause of a	leath (Item 23a) (Type			e Dn	SALLINIE	x MD 21804
	Sta		31. Date filed (Month, Day, Yea	1.	ar's Signature	111166	- i juice	- V/L	2016/1/1000	7 111 -1007
	Registr	ar	JAN 20	1 2009 /2	. A las	2. 4. 1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2009 11:45 Margaret Louise Duvall January 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery

9. Birthplace (State or Foreign Country) Olney If Under 1 Year <u> Montgomery General Hospital</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Social Security Number 6. Sex Months Days Hours Min. 1 □ M 2 🗓 F 88 Oct. 1, 1920 Maryland 214-12-7499 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 TNo Maryland Montgomery Damascus 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 9507 Pleasant Plains Road 20872 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married 1 □Yes 2 🖔 No Specify 3 X Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daisy Benson Charles Musgrove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard B. Duvall, son <u>3904 Flavia Court, Williamsburg, Virginia 23188</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation S ☐ Other (Specify) Damascus Methodist Cemetery Damascus, Maryland 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Fun ral Service License 26401 Ridge Road, Damascus, Maryland 20872 en 23a. Par ... nite the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shr k, or h-art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting in neephalopa CACYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disase or hijiny) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be ၉

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evaminar must be notified at

Maryland 21215-0036

altimore,

and use as the burial-trar attending physician for use as the burial signed by the a d be detached fo page 2 s has certificate this

Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Records,

of Vital

Division Hospital or Attending

Physician/Medical Examiner Completed by Be Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

10 State

Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Rd

Obey, MI)

29d. Date signed (Month, Day, Year)

12, 2009

DHMH 17 Rev 1/2001

oney- Lightonsville

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATHUR

		-	State of Maryla	•	artment of H <i>rtificate of L</i>		lental Hygi	ene g. No. 2009	02580
			1. Decedent's Name (First, Middle, Last)	061	Timeate of L	Jeann	2. Date of Death		3. Time of Death
	Physicia		Eleanor L.	Div	ver		January		11:26 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
٠, ٠			Kline Hospice House		Mt. Air	•		Frederic	
ı	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 1 ☐ F 83	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Aug. 30,	Year) 9. Birth 1925 Wash	place (State or Foreign ntry) ington, DC
-			Usual Residence of Decedent						
	show	_		City, Town or Lo					10d. Inside City Limits 1 □Yes 2 →No
	be Ma	ecto			10f. Zip Code	_	1 10	g. Citizen of What Cou	
	with t	Ρ	10e. Street and Number 9421 Highlander Court		2179	3	10	USA	ing :
	ms 2:	nera	11 Movital Status 12 Was Decedent Ever in	n U.S. 13.	Was Decedent of H	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, it is becaling a some once.	by Funeral Director	Armed Forces?  1 Never Married 2 Married 1 Yes 2 MNo 1 Widowed 4 Divorced Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	Specify:	nicali, etc.)	Black, White, Specify: Wh	ite
S S	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	i (Give	edent's Usual Occup	luring most of work	ing 1	6b. Kind of Business/Ir	dustry
7	vithin ane. <b>than</b> "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired es Clerk	)		Retail	
70	filed v Hygie other 1	ပ္ပ	17. Father's Name (First, Middle, Last)	Sal	es Clerk	18. Mother's Name	e (First, Middle, M		
/land	ild be fental rked o	To Be	Timothy Cremin	ıs		Gene	ive	Willia	mson
Mary	and N		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Zi	
ა დ	and 2 Health m 27 i		Glenda Segreti/Daughter					ville, MD	
baltimore,	ages 1 ant of h t; If ite y or ot				osition (Name of matory or other place	e)		Rockville,	
altil	mit. P partme sortan / injur		21. Signature of Funeral Service Licensee	2	2. Name and Addres	ss of Facility Sta	uffer Fu	neral Home	, PA
מ	a m lo lo lo lo lo lo lo lo lo lo lo lo lo		1 Kozulmolo	1	621 Oposs	umtown Pi	ke, Fred	erick,MD 2	1702
			23a. Part Enter the disease, or complications that caused the cashock, or heart failure. List only one cause on each line.	leath. Do not en	iter the mode of dyir	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
4.00-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	2120	Syndr	Ime			1 wek
	Examiner		Due to (or as a con	sequence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Unitarity is Cause (Disease or injury that initiated events	sequence of):					
	ecute and transi	Examiner	Cause (Disease or injury that initiated events c	poguence of:					
8760,	icate be executed physician and the burial-transit	cal E	Due to (or as a con	sequence on.					
28	ifficate g phys	ᇹ	a						
ROX	<ul> <li>requires that the death certificates</li> <li>been signed by the attending should be detached for use as</li> </ul>	sician/Me	IF FEMALE: 23c. If yes, outcome of pre 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐	Fetal death 3	☐ Ectopic pregnanc	y		23d. Date of deliv	very Day Year
o.	the de y the a ched fi	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of death 5	Other (specify) _				
٠ <u>٠</u>	requires that the been signed by th hould be detache	by Phys	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	equires en sig ould be	ed b	Alzheimers Olmen	Ka			1 □ Ye	s 2 <b>0 Ho</b> 3 □ Pro	bably 4 Unknown
Vital Records,	12 35 a	Completed					24a. Was ar	/ prior to c	opsy findings available ompletion of cause of
<u>=</u>	sician: The law certificate has b rector, page 2 si	Com					perform	ed?   death?	2  No
VII	ician certifi ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		ont 3 DOA Oth	or:	th (Check only one		Hospice
ō	Phys r this ral dir	.T	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatie	SIII 3 LI DOA	4 LI Nursing H	ome 5 Reside 28d. Describe ho	nce 6 X Other (Spec w injury occurred	ify) House
<u></u>	nding tth. ; Afte e fune	atior	1 Natural 5 ☐ Pending (Month, Day, Yea 2 ☐ Accident investigation	ar) Injury	Wor	ć? Yes 2 □No			
Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, st	treet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	pital o		29a. Certifier Decertifying Physician: To the best of my	knowledge des	ath occurred at the ti	me date and place	and due to the co	ause(s) and manner as	stated
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
	vithi Vom	Ž	29b. Signature and title of certifier		29c. Licens	_		d. Date signed (Month	
			Yeugh hous			310 58		1-16-0	79
	(4)	1	30. Name and address of person who completed cause of death  Gene Ashe 10200 Coppermine			MD			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's S	signature	arked	,	-		
	Registr		JAN 16 2000 / Lean	19					

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:00 A<sup>M</sup> 2009 January Jean Ann Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1016-F Stark Street Frederick Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Aug 24, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢 F 556-74-0142 1947 California 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 1X Yes 2 □ No Director CA Humboldt Fortuna the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 95540 2974 Van Duzen Street USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event. It is in a page. Black. White, etc 1 ∐Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse <u>Healthcare</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Peter Sorensen Virginia Katherine Kennedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Sorensen/son 1016-F Stark Street Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arundel Crematory 01/20/09 Odenton, MD Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Lice MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cervical Cancer 1 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie D54749 number 29d. Date signed (Month, Day, Year) January 20, 2009 Allen Reilly, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (x)03 Allen Reilly, M.D. 801 Toll House Ave. D-1 Frederick, MD 21701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN20 parke Registrar MARINA

DHMH 17 Rev 1/2001

# VOID

# CERTIFICATE #

2009-02582

SEE

CERTIFICATE #

2008 - 43756

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:00 P M Donald Otto Foster 13, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9026 Emory Grove Road Gaithersburg
If Under 1 Year | If Under 24 I
Months Days Hours N Montgomery

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 9. Birthplace (St Country)
July 27,1932 Maryland Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Yrs. 231-34-5365 76 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show event, the Medical Examiner roust be notified at Maryland Montgomery Gaithersburg 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9026 Emory Grove Road 20877 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1953-1 ☐ Never Married 2 X Married 0, Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify Specify: þ 3 Widowed 4 Divorced 1955 White "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Facilities Maintenance Specialist 16b. Kind of Business/Industry
National Parks 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Wolce. Elementary/Secondary (0-12) College (1-4or 5+) Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Otis Foster Nettie E. Claig ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9026 Emory Grove Road, Gaithersburg, MD 20877 Eva C. Foster 20b. Place of Disposition (Name of cemetery crematory or other place)
Forest Oak
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 17, Gaithersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home. 21. Signature of Funeral Service Licensee witer 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Cancer **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed anding physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After tilled in by the funers After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 □No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

To the Hospital c within 24 hours af To the Funeral D completely filled i

2+1

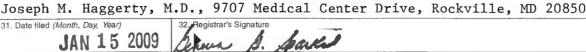
State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

40seph MI

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D32407

29d. Date signed (Month. Day. Year)

January 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ĬŸ, 2009 **Physician** 8:10A. Flaxman January Judith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Chevy Chase 3213 Farmington Road 9. Birthplace (State or Foreign Country) Rhode Island If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) June 21, 1965 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 43 013-58-1544 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Evaning must be resilied at aprile. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Chevy Chase Montgomery Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number United States 20815 3213 Farmington Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 11. Marital Status Black White, etc. 1 Never Married 2 Married Whi te 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4055+) Elementary/Secondary (0-12) Self Employed Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leven Rhoda Flaxman Bertram Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3213 Farmington Drive Chevy Chase, Maryland 20815 Jonathan S. Martel -husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Buriat 2 ☐ Cremation 3 ☐ Removal from State 1/18/2009 Garden of Remembrance Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 years **Physician** Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-trans attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed funeral director. Be Medical Certification; To After this death. the

Division of Vital Records, P.O. Box 68760, To the Hospital or Attence within 24 hours after death To the Funeral Director: filled in by completely

										24a. Was an autopsy performed? 1 □ Yes 2 X No	prior to comp death?	y findings available eletion of cause of
25	Was case referred to	medical						26. Place of Dea	ath (Ch	heck only one)		
	examiner? 1 ☐ Yes 2 🂢 No		Hospital	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 [	OOA	Other: 4 Nursing H	lome	5X Residence 6	☐Other (Specify)	
27.	Manner of Death 1 Natural 5 2 Accident	Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М		Injury at Work? 1 □ Yes 2 □ No	28d.	Describe how injury	occurred	
	3 Suicide 6 4 Homicide	Could not be determined	28e.	Place of Injury - At h building, etc. (Special	ome, farm, stree	et, facto	ory, of	fice		Location (Street and City or Town, State)		loute Number,
29	a. Certifier 1X (Check only 2	CertifyIng Phy Medicel Exam	iner: Or	To the best of my known the basis of examinated manner stated.	owledge, death ation and/or inve	occurre	ed at to	the time, date and place my opinion, death occu	e, and urred a	due to the cause(s) at the time, date and	and manner as star place, and due to the	ed. ne cause(s)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number D33037 January 14, 2009

Andrew T. Putnam, M.D. Lombardi Cancer Ctr. 3800 Reservoir Road, N.W. Washington, D.C.

State Registrar

09-00514 Donald George Fentress Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

7007 0700	2009 025	085
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		- For State		Cer	tificate (	of Deat	h			Re	g. No.		
Physicia	n/	1. Decedent's Name (First, Midd		T1 (						Date of Deat Month	Day Yes		3. Time of Death 1026 hrs
ical Examir			nald Geor		ess	1				January 18	3, 2009 4c. County	of Dooth	1020 1115
		4a. Facility Name (if not instituti 12468 Lime Kiln Roa		umber)		4b. City, Fulto	Town, or Lo	ocation of	Death		Howard		
				7. Age (In yrs. Ia	ast hirthday)		ler 1 Year	If Under	24Hrs	8 Date of Birt	h(MM/DD/YYY		pplace (State or
Funeral		5. Social Security Number	6. Sex			Month		Hours	Min.	09/19,		Foreign	
Director		212 36 7592	1 X M 2 F	70		rs.				03/13/	1930	000	
80	<b>⊢</b>	Usual Residence of Decedent  10a, State 10b, County	,	10c. City.	Town or Loc	cation							10d. Inside City Limits
w any			vard		ılton								1 Yes 2 No
yland -f sh	후	10e. Street and Number	vard			10f. Zij	o Code			10	g. Citizen of W	hat Coun	try?
Mar r 28a	Director		D4				2075	.a			Unite	d Sta	ates
or items 23a or 28a-f show must be notified at once.		12530 Marlow		ecedent Ever in U.	S 13 V	Was Deced			n? (Spec	cify Yes or No-			an Indian, Black,
ath wi	Funeral	1 Never Married 2 X	Married Armed F	Forces?		f Yes, spec	ify Cuban.	Mexican,	Puerto R	can, etc.)		te, etc.	
er der		3 Widowed 4 D	1 X Yes	2∐ No earunknowr	1 1	Yes 2	X No	specify:			Specify:	Wh	ite
5-0036 led within 72 hours after they within 72 hours after dynum "matural", other than "matural", the Medical Examiner	<u>a</u>	15. Decedent's Education (Sp	or Dales:		16a. Deced	dent's Usua	Occupation	n (Give ki	ind of wo	rk done	16b. Kind of B	usiness/Ir	ndustry
2 hou	Completed	Elementary/Secondary (0-12		(1-4 or 5+)	during	most of wo	orking life. I	JONOL	ise retire	<b>a</b> )			
336 thin 7 than than	ā		1		Li	ghtin					<u> </u>		Lightbulbs
5-0036 Thed within 7 Hygiene d other than the Medica	3	17. Father's Name (First, Middle	le, Last)						,	irst, Middle, M	Maiden Surnam	e)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than e event, the Medical	Be	Lee Fentress				~		idna i					7 0 11)
mid 2 should be filealth and Mental Eealth and Mental Item 27 is marked transmatic event,	2	19a. Informant's Name/Relation									nber, City or To		
MD of 2 she alth and in 27 is animati	,	Teresa H. Fer	ntress/Wif	:e	Place of Dis					W RG F	ulton,		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland and of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once	1	1 Burial 2 Cremati	on 3 Removal	from State	crematory or	other place	e)				D-14a	N/I	
imore Pages la nent of He ant: If it		4 Donation 5 Other	Specify:	St							Fulto		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If tiem 27 is marked other thinjury or other transmatic event, the Mex.		21. Signature of Funeral Service	ce Licensee	@ M010									ily FH Inc.
		23a. Part I. Enter the disease,	~ /W	anyond the death	Do not ent	4112	Old C	OLUM	bla erdiac or i	PIKE E	LL1COTT est. shock, or h	eart	y, MD 21043 Approximate Interval
Physician Medical		failure. List only one caus	se on each line				or dying, c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					Between Onset and Death
Examiner		Immediate Cause (Final diseasor condition resulting in death)		erotic Cardio		Disease			_				
			b.	a consequence	51).								
	je.	Sequentially list conditions, if any, leading to immediate	·	a consequence of	of).								
	Examiner	(Disease or injury that initiated	Dun 40 (05 00	a consequence	of)								
led msit	Exa	events resulting in death) Las	d d	a consequence									
760, icate he executed physician and the burial - transit	Medical	UNPENDED	AMENDE	)									
760, Trate be a physicia the burit	Jed	IF FEMALE:	23c. If <b>ve</b> s	s, outcome of pres	gnancy						23d. Date	of delivery	
687 certifica Iding pl	an/l	23b. Was decedent pregnant in past 12 months?	LIVE			Fetal deat	h 3	Ectopic	pregnan	су	Month	D	Day Year
Box 687 he death certific	sician		Jalana 17 H	gnant at time of d	eath 5	Other (Sp	ecify)				ľ		
be der	Phy	Part II. Other significant con-	19 011		resulting in t	he underlyii	ng cause g	iven in Pa	rt I.	23e. Did t	obacco use con	tribute to	the cause of death?
cords, P.O. Box 68' law requires that the death certifi has been signed by the attending 2 should be detached for use as:	by	Tare in Other organization		,						1 Ye	s 2 🗸 No :	3 Prob	pably 4 Unknown
S, and a signal of the pe	ted									24a Was			topsy findings available
OFC aw re nas be 2 sho	ed d										rmed?	death?	completion of cause of
Rec The cate	Completed						00.5	( D II	(O) 1 - + -		2 No	1 Ye	es 2 No
tal Rection: The certificate	Be (	25. Was case referred to med examiner?	Hospital:	1	ER/Outpat	iont 2		of Death		Home 5	Residence 6	Other	Scene
<u>≥ iš</u> iį į į	၉	1 Yes 2 No 27. Manner of Death		Inpatient 2_	28b. Time		28c. Injur				how injury occu		
n of ding Pt 1. After funeral	ä	1 Netural	(Mo	nth, Day, Year)				es 2					
IVISION Ior Attendather death Director:	cati		vestigation	ace of Injury - At I	home farm	street facto				28f. Location (	Street and Num	ber or Ru	ral Route Number, City
Division tal or Attendi ars after death.	Certification:	de de	ould not be etermined (Special				,			or Town,	State)		
Division of Vital   Division of Vital   Within 24 hours after death. To the Funeral Director. After this certificompletely filled in by the funeral director.		4 Homicide 29a. Certifier	Physician: To the t	pest of my knowle	dge, death o	ccurred at t	he time, da	ite and pla	ace, and	due to the cau	se(s) and mann	er as stat	ed.
To the II. Within 24 To the Fo	Medical	(Check only one) 2 Medical E	xaminer: On the bas	is of examination	and/or inves	tigation, in	my opinion	death oc	curred at	the time, date	and place, and	due to th	e cause(s)
To the within To the comple	Mec	29b. Signature and title of cer	and/manne tifier	stated		2	29c. License	e number			29d. Date sig	gned (Mo	nth, Day, Year)
							O.C.	M.E.			January 2	20, 2009	9
(1041) 02		30. Name and ad year of per	on who completed c	ause of death (Ite	m 23a)								
OCME		Mary G. Ripple MD.	Deputy Chie	f Medical Exa	aminer	111 Pen	n Street	Baltim	ore, M	21201			
s	tate	V I A B A B A C	2009 32	Registrar's Signa	ture	park	1						
Regis		יאותט	₩ U ZUUJ /	VIVIO I	p. 7	July or							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** GEORGE WILLIAM GROVE, Jr. 19. 2009 <u>January</u> P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN\_VILLAGE HAGERSTOWN WASHINGTON Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1X M 2 □ F Months Days Hours 174-20-2659 Director 80 12, 1928 Waynesboro, Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗖 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1183 Luther Dr. 21740 US death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc be filed within 72 hours after 1X□Yes 2□N1948-If Yes, Give Year or Dates: 1951 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telescope operator observatory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be.
Department of Health and Mental I.
Important if them 27 is marked any injury or other any once. Be George W. Grove, Sr. Ruby A. McCoy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Vance P.O. Box 142 Green Bank, WV 24944 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Green Hill Cemetery January 23, 2009 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ir 50 S. Broad St. Waynesboro, PA 17268 23a. Art1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary alter disease many years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, a 2 mg to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached for P.O. I 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ Anemiou 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been s funeral director, page 2 should Completed GERD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 □ No Depression 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 MILL STREET, Hagerstown, 21740, MD 3,6-6+ AndaleeD All 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2009 back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9

		-	For State Registrar	,	ertificate of	Death	Re	eg. No.	
1			Decedent's Name (First, Middle, Last)				2. Date of Death	h Dav Year	3. Time of Death
	Physici	_	Ferguson	Gemeny, Sr.			January	19, 2009	3:40 A.M
,	/Medic Examin		4a. Facility Name (If not institution, give :		4b. City, Town, o	r Location of Deat	h	4c. County of Death	1
- #	LAGITIII	-1	Calvert Memoria		Prin	ce Fredei	rick	Cal	vert
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) Con	nplace (State or Foreign untry)
	Director		578-07-8979	]M 2□F 99 Yr	s.		03/08/1	909 Mar	yland
	р. <b>"</b>		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits
	aryla shov	_				1.			1 ☐ Yes 2 ☐ No
	8a-1	Director	MD Calvert	Pri	nce Freder	1CK	11	0g. Citizen of What Co	21
	vith th	듬	10e. Street and Number	1		0678		U.S.A	
	e 23a	Funeral	85 Hospital Ro	12. Was Decedent Ever in U.S.			Specify Yes or No-	14. Race - Amer	
	itsm itsm	Ë	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces?	13. Was Decedent of H If Yes, specify Cub		to Rican, etc.)	Black, White	
36	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f show deal Examiner must be notified at	by F	3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:	1 ☐ Yes 2 🗓 No	Specify:		Specify: W	hite
ဗို	2 hou	ed	15. Decedent's Edu		ecedent's Usual Occup	pation		16b. Kind of Business/	ndustry
21215-0036	7 oir	Completed	(Specify only highest grad	College (1-4or 5+)	Give kind of work done ife. DO NOT use retire	d)	rking		
2	d with	E	12		florist			flower s	hop
5	al Hy othe	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	
<u>a</u>	Menta Menta arked arked	2	Edgar Dean (	Gemeny		Eva	Frances	Ferguson	
altimore, Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene. If item 27 is marked other than "naturs!", or itsme 23a or 28a-1 show or other traumatic event, the Medical Examinat man be notified at	(d) - [	19a. Informant's Name/Relationship (T)					, City or Town, State, 2	
≥,	and ealth m 27		Ferguson Gemeny,		7 Nottingh Disposition (Name of	am Dr., (		Heights, V.	
ore	of H if its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	cemetery	crematory or other pla				
Ë	Pag ment tant:		4 ☐ Donation 5 ☐ Other (Specify,	-	y Cemetery			Prince Fred	
Ball	permit. Pages 1 Department of H Important: if its any injury or ott		21. Signature of Funeral Service Licens	·	22. Name and Addre	Use Pacility R	ausch Fun	eral Home,	P.A. 0736
	20 E # 0		23a. Part1. Enter the disease, or comp	Mulacel Barrens	8325 Mt.				Approximate
		ľ.	shock, or healt fallure. List only of	ne cause on each line.					Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Acute Mo Due to (or as a consequence of b. Atheroscler	yo cardi	a) In	Farctio	on	
1	/Medical Examiner		Tospining in obaciny	Due to (or as a consequence of	):		. 140 0	110010	
		e	Sequentially list conditions, if any, leading to immediate	b. Therosclen  Due to (or as a consequence of	ofic car	arovaso	ulous a	rase	
	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury	,					
	and and el-tra	Examin	that initiated events resulting in death) Last	C	j):				
68760,	sicier s buri			d					
68	The law requires that the death certificate be executed as been signed by the attending physicien and bage 2 should be detached for use as the buriet-transit	Medical							
Box	eath cert attendin for use		23b. was decedent pregnant	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death	3 Ectopic pregnance	CV		23d. Date of de Month	lvery Day Year
	deat e attr	icia	in the past 12 months?	4 Pregnant at time of death	5 Other (specify)			Month	Day 16a1
P.0	res that the de signed by the a be detached to	Physician/	9 Unknown			1. 0. 41	220 Did to	bacco use contribute to	the cause of death?
	es this gned be de		Part II. Other significant conditions of	ntributing to death but not resulting in	the underlying cause g	iven in Part I.			robably 4 Dunknown
ord	w require been si should b	ted	sephe sh	ocic -					
မင္ပ	has be	pie	Acute Re	nal Fleiwre	2		24a. Was autop	sy prior to	utopsy findings available completion of cause of
of Vital Records,		Completed by	Peripheral	Arterial d	isease		1 Yes	med? death? 2 No 1 ☐ Yes	2 □ No
ita	Physicien: Th rthis certificate ral director, pag	Be (	25. Was case referred to medical examiner?				eath Check only or	ne)	
₹	Physic this or al dire	ျ	1 ☐ Yes 2 ▼No		patient 300A			lence 6 Other (Spe	icify)
	e fe		27. Manner of Death 1 ☑ Natural 5 ☑ Pending		jury W		28a. Describe n	low injury occurred	
sio	Attending ir death. ector: Atter by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be			]Yes 2 □No	28f Location (S	Street and Number or R	ural Route Number
Division	or At fler d jirect in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	<del>)</del>	City or Ton		arar real areas
۵	urs a		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge	death occurred at the	time, data and plac	ce and due to the	cause(s) and manner a	s stated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	Vor investigation, in my	opinion, death oc	curred at the time,	date and place, and du-	e to the cause(s)
	o the	Me	29b. Signature and title of certifier			nse number		29d. Date signed (Mon	
	⊢ ≯ ⊢ ŏ		Ceyo	r-C. Juna	a D	.5065	3	1-19-2	2009
			30. Name and address of person who	completed cause of death (Item 23a) (				Ð	
			5851 - Dea				1e m2		
	St.	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
ė	Regis	trar	JAN 20 2009	Enewa B. park	1				
DI	HMH 17 Rev 1/	2001		7					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2140 Joanne 14 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1  $\square$  M Yrs **Director** 215-38-4144 69 2, 1939 Nov. Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 No 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 127 Talbott Street 20852 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes. Give 1 Yes 2 No Specify. Completed by Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 2 should be filed within and Mental Hygiene. College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and M Robert Bowie Kisner Rose Rebecca Embrey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Hamburg / Daughter 4715 Teen Barnes Road, Frederick, MD 21703 item 27 20a Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/16/09 Smithsburg, Maryland 21. Signature of Funeral Service Licensee ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Tull 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Pulseless **Physician** Electrical minutes /Medical **Examiner** 2 months diomycpath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed Heart Failure 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has performed this certificate completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Nnpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ည 5 🗌 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Hospital or Attending Pt
 24 hours after death.
 Funeral Director: After th 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and manner stated. To the I within 2 29d. Date signed (Month, Day, Year)

Marisha L Co 31. Date filed (Month, Day, Year)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

faces

RES

Januari

600 North Wolfe St, Baltimore, MD, 21287

State

Registrar

		For State Registrar		State of	f Marylan		artment of H tificate of L		Mental Hy	giene Reg. No.	0000	02589
			me (First, Middle, Las	t)		<i>C</i> .			2. Date of De			3. Time of Death
Physic /Medi		Betty	(If not institution, give		aherl	Gi	105 PIC 4b. City, Town, or	Location of Deat	Janvari	1 15		0112 A M
Exami	ner		Hopkins H				Baltimore				None	
Funeral		5. Social Security 219–10–3	Number 6. S		7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	l	place (State or Foreign itry)
Director		Usual Residence			84				10-15-	1924	MD	
arylanc show 1 at	ž	10a. State	10b. County			ty, Town or Lo icott (						10d. Inside City Limits 1 ☐ Yes    Yes
the Ma 28a-f	recto	MD 10e, Street and N	Howard umber		Lili	TOOLL V	10f. Zip-Code			10g. Citi	zen of What Cour	
th with 23a or st be r	al Di	8720 Rid					21043			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1 □ Never Ma	rried 2 Married	12. Was Dece Armed Fo 1 Tes If Yes, Giv	2CXNo		Was Decedent of H If Yes, specify Cuba 1 □ Yes 🍇 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	)-	14. Race - Americ Black, White,	etc.
hours a ural", c	d by	₩Widowed	4 Divorced	Year or Da	e ates:		dent's Usual Occup			16b. K	Specity: Whi	
nin 72 in "nat Medica	Completed		ecify only highest gra		-4 or 5+)	(Give	kind of work done DO NOT use retired	during most of wo	orking			
ed with ygiene ner tha	Con	Elementary/Se	12			Bank '	Teller	18 Mother's Na	ame (First, Middl		king	
d be fill antal H ced oth	To Be	George M						Lillian		o, maraor	, damamo,	
2 should and Men is marke		19a. Informant's I	Name/Relationship (	Type. Print)		19b. Maili	ng Address (Street	and Number or F	Rural Route Num	ber, City o	or Town, State, Zij	o Code)
E, N 1 and 2 Health a tem 27 is			a Booze /	Daughte			Brittany		Llicott		, MD 210 ocation - City or To	
Pages 1 Pent of H Int: If ite			2 Cremation  2 Other (Specif		Diale		osition (Name of matory or other place	i	7-2009		timore,	
Dallillor permit. Pages Department of Important: If it any injury or of			neral Service Lice		M0141	1 2	Cemetery 2. Name and Addre	ess of Facilit Hai	rry H. W	itzk	e's Fami	1y F.H.
		23a Part 1 Enter	the disease, or com	plications that o	aused the deat	. 4	112 Old C	Columbia ng. such as cardi	Pike, E	11ic	ott City	MD 21043 Approximate
Physician	ı	shock, or he Immediate Cause	eart failure. List only e (Final	one cause on e	ach line.	.L. 1	3					Interval Between Onset and Death
/Medical		disease or condit resulting in death		a. Due to	(or as a consec	quence of):	TC-VV	orrhoge				
Examiner	ē	Sequentially list of if any, leading to	conditions,	b	(or as a consec	quence of):						
uted 1 ansit	Examiner	cause. Enter Und Cause (Disease of that initiated ever	derlying	C.		,						
cate be executed physician and sthe burial-transit		resulting in death	) Last	Due to	(or as a consec	quence of):						
or our	edical		•	d								
The Cords, F.O. Box or The law requires that the death certific the has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceded in the past 1		1 Live I	tcome of pregribirth 2 - Fet	al death 3	☐ Ectopic pregnanc	су			23d. Date of deliver Month	very Day Year
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s that the property of deta	by Pl	Part II. Other sig	nificant conditions	contributing to c	leath but not re	sulting in the	underlying cause g	iven in Part I.			. /	the cause of death?
cords, w requires t been signe should be												bably 4 Unknown opsy findings available
e law r has be ge 2 st	Completed								24a. Was auto perf		prior to c death?	ompletion of cause of
VITAL   clan: Th ertificate ector, pa	Be Co	25. Was case refe	erred to medical			-		26. Place of De	1 ☐ Yes eath (Check only		1 Tes	2 NO
Of V Physicil	10 E		No		<u> </u>	ER/Outpatie		4 🗆 Nursing			6 Other (Special	fy)
SION (sending P eath. or: After the funera	tion:	27. Manner of De 1 Natural 2 Accident	5 Pending		th, Day Year)	28b. Time o Injury	Wor	ryat k? ∣Yes 2.∐No	28d. Describe	r now mju	ry occurred	
DIVISIO I or Attendi after death. Director: A	Certification:	3 Suicide	6 Could not b	ZOC. I lace	of injury - At h	ome, farm, st	reet, factory, office		28f. Location City or To			ral Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has loompletely filled in by the funeral director, page 2		29a. Certifier					h occurred at the ti					
To the Hospital within 24 hours of To the Funeral Completely filled	Medical	(check only one)			nasis of examin ner stated.	ation and/or if	nvestigation, in my		curred at the time		ite signed (Month)	
P vith	2	29b. Signature ar	7				29c. Licens	9142		29u. Da	i	009
(q) 02		30. Name and ad	dress of person who	completed cau	se of death (Ite	em 23a) (Type	, Print)		. N	16 6		
(a) NO	ate	MELIS 31. Date filed (Mo	SA MS	32.	egistrar's Sign	ature	•	600	North W	oife S	it, Baltimo	re, MD, 21287
Regis			JAN 162	- A	neur	B. A	arkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $\mathbf{A}^\mathsf{M}$ **Physician** 26, 0533 January 2009 Donald Andrew Gividen, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🔀 M 2 🗆 F Yrs. FEB 28. 1948 Indiana Director 220-50-3167 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Examiner must be notified at 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ▼No Funeral Director E1kton Maryland | Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 126 Marley Road 21921 12. Was Decedent Ever in U.S.
Armed Forces?
1 M Yes 2 □ No
If \$\text{fes}\$, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 2 🕱 No 3altimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Government Hazardous Materials Handler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Buckley Donald Clarence Gividen ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 126 Marley Road, Elkton, MD Teresa A. Gividen/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 27, Department of important: If it any Injury or or 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. 2009 West Chester, PA <sup>22. Name and Address of Facility</sup> Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Pulmoning Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aca de Sequentially list conditions, it are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Division of Vital Records, ģ HYPERLIPIDEMIA 12 7es 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1t Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier
(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only one) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lamita hei

Registrar

31. Date fred (Month, Day, Year) FFR 0 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOSPITAL.

ELIKTON

			1 - For State Registrar		partment of Health and I ertificate of Death	Mental Hygie	2009 02591
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia /Medic		Edmond Boyd Harde	sty,Sr.		January	18, 2009 22:07 M
	Examin	54	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	1	4c. County of Death
			Washington County 5. Social Security Number 6. Sex		Hagerstown  V) If Under 1 Year   If Under 24 Hrs.	9. Date of Righ	Washington  9. Birthplace (State or Foreign
	Funeral Director			XM 2□ F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 22	(ear) Country)  1930 Mary Land
	ס		Usual Residence of Decedent			MPITI ZZ	
	anylan show		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
	8a-f	ecto	Maryland Washingto	on Hagers		10-	1 □ Yes 2XXVo
	with t	급	10e. Street and Number		10f. Zip Code 21740	109	). Citizen of What Country?  USA
	ms 23	era	18608 Wilderness Wa	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
ထွ	within 72 hours after death with the Maryland ene. than "naturel", or Itams 23a or 28a-f show he Medical Examiner must be notified at	by Funeral Director	1 Never Married 2 XX Married	Armed Forces?  1 X Yes 2 No 1947—  If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	o Hican, etc.)	Black, White, etc.
21215-0036	ure!',	d by	3 Widowed 4 Divorced	Year or Dates: 1950			Specify: White
<u>7</u>	"nat	Completed	15. Decedent's Educ (Specify only highest grade	e completed) (Gir	cedent's Usual Occupation ve kind of work done during most of wor b. DO NDT use retired)	king 16	b. Kind of Business/Industry
7	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	ocker		Grocery
	a filled of her other rent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)
/lar	uld by Menta arked	ToE	George Norris Har	desty	Helen R	lebecca Edi	munds
Maryland	2 sho and ls ma	1	19a. Informant's Name/Relationship (Type	pe, Print) 19b. Ma	illing Address (Street and Number or Ru	ıral Route Number, C	City or Town, State, Zip Code)
	1 and 1ealth Im 27 Iher tr	9	Barbara D. Hoyt - [		08 Wilderness Way		wn MD 21740 lc. Location - City or Town, State
ğ	ages nt of th		1 ☐ Burial 2 ☑ Cremation 3 ☐ R	temoval from State cemetery, ca	rematory or other place)		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Itams 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Fineral Service Lens		urg Crematory 01-22 22. Name and Address of Facility Os		nithsburg,Maryland
ä	Depar Impo any ir		in Z. (Al	/	US		eral Home,P.A. liamsport.MD 21795
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death. Do not e			
	Physician	2 1	immediate Cause (Final disease or condition	•			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	2		
i.	LAGIIIII C.	<u>.</u>	Sequentially list conditions,	Due to (or as a consequence of):	enotic andi	5 varen	lu
	nted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Edo to (or as a consequence or).		1)23	ونسو
Ć.	execu in and ial-tra	Exal	that initiated events cresulting in death) Last	Due to (or as a consequence of):			
8760,	ficate be executed physician and is the burial-transit	dical		i			
9	artifica ing ph e as ti		IF FEMALE:				
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death.  Nithin 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of delivery  Month Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 5 9□ Unknown	5 ☐ Other (specify)		
	res that i	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
rds	w requires been sign should be					1 ☐ Yes	2 No 3 Probably 4 Unknown
Vital Records,	aw requis been 2 shoulk	Completed				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
ž	The I	Com				autopsy performe	d? death?
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5	hysic this co	2	1 Yes 2 No	lospital: 1 Inpatient 2 ER/Outpati			ce 6 ☐Other (Specify)
Division of	ding Physicien: The lav n. After this certificate has funeral director, page 2	lon:	27. Manner of Death Natural 5 Pending investigation	28a. Date of Injury 28b. Time (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 \( \text{Y Yes} \) 2 \( \text{No} \)	28d. Describe how	injury occurred
isi	death death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,			et and Number or Rural Route Number,
$\frac{1}{2}$	al or after	Certification:	4  Homicide determined	building, etc. (Specify)		City or Town, S	State)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the			sician: To the best of my knowledge, de ner: On the basis of examination and/or			
	To the H within 24 To the F complete	Medical	one)	and manner stated.	CO. Linear analysis	ned at the time, date	Data size of (Month Pau Vani)
ŀ	To Yourt	~	23D. Signature and tipe of certifier	5 Stolles min	Discontinuation 2	_ 290	Tan 21. 2613 9
•			, 10000	moleted source of death /hom 23a) /Tur	2 1		
			30 Name and address of person who co				
2	SH K+1		Edward w D	EHO IETA	To of archite	Hosens for	ms (40) 22 74
	)H 5+1 Sta	ite	29b. Signature and title of certifier  Sure L. N.  30. Name and address of person who co  E. L. W. 2 V. L. W.  31. Date filed (Month, Day, Year)  JAN 2 2 2	32. Registrar's Signature	4, of archite	Hegers for	ms chel 22 Frfs

				State of Man				ental Hyg	iene	
		•	For State Registrar		Ce	rtificate of	Death	Re	eg. No.2 0 0 9	02592
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day Year	3. Time of Death
1	/Medic	_		ampton				January		
	Examir	er	4a. Facility Name (If not institution, give s			Chever	or Location of Death		4c. County of Dea	
	Eunaral		Prince George H  5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
г	Funeral Director			IM 2XF 59	Yrs.	Months Days	Hours Min.	(Month, Day,		
	pu ,		Usual Residence of Decedent		0c. City, Town or Lo	nantion				10d. Inside City Limits
	shov shov	٦	Md Prince G	Í	Glenard					1 Ty Yes 2 □ No
	the M	Director	10e. Street and Number	eorge	orenara.	10f. Zip Code		11	0g. Citizen of What C	
	3a or		1517 2nd Street			20706				
	ms 2:	Funeral		12. Was Decedent Eve Armed Forces?	er in U.S. 13.		Hispanic Origin? (Sper pan, Mexican, Puerto F	cify Yes or No-	14. Race - Am Black, Whi	
ဖွ	after or ite		1 ☐ Never Married 2X Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☑ No		tiodit, oto.)	Specify: B1	_
8	be filed within 72 hours after death with the Maryland that Hygliene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	160 Dags	dent's Usual Occu	notion		16b. Kind of Business	
15	n 72 l	olete	15. Decedent's Educ (Specify only highest grade	e completed)	(Give	kind of work done  DO NOT use retire	during most of workired)	ng	Tob. Killa of Business	industry
712	l within jiene. r than " the Med	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	ŀ	ician			vt Indus	stry
פ	e filed al Hygi other vent, t	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	Maiden Surname)	
<u>Ja</u>	should be and Mental s marked o umatic eve	2	Clifton Jackso	n			Carrie H	Iall		
lar			19a. Informant's Name/Relationship (Type			•			; City or Town, State,	•
6,	1 and 2 Health em 27 I		Perry Hampton (H	usband)					Md. 20706	
Baltimore, Maryland 21215-0036			1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Disposemetery, cre Fort Lin				ladensbu	
Ħ			4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Functal Service License	ee		2. Name and Addre		7-2007		20011
Ba	permit. Departr Imports any Inj	5 3	1 12000 V	10000	-/ l	yrone J	. Young	719 Ke		. NW Wash
	- 40		23a. Part1. Fitter the disease, or complishoot, of heart failure. List only or	catens that caused the	death. Do not en	ter the mode of dyi	ing, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
7	Physician		Immediate Cause (Final disease or condition	0 13	reas.		arcino			Onset and Death
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9	eath certificate attending phy for use as the					* **				
Вох	th cer tendir r use	an/N	23b. was decedent pregnant	3c. If yes, outcome pf 1□Live birth 2		□Ectopic pregnanc	cv		23d. Date of de	,
	e dea the at red fo	Physician/Medi	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at tir 9□Unknown		Other (specify)	-		Month	Day Year
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or Vital Records,	signe d be	l by			<b>3</b>	,g		1 □ Y		Probably 4 Unknown
CO	w requir been sl should b	Completed						24a. Was a	n 24h Were s	utopsy findings available
Re	The law	dmc					<del></del>	autops perfori	med? prior to	completion of cause of
ta	(6 (1		25. Was case referred to medical	15-1			26. Place of Death		2 <b>Y</b> No 1 Ye	s 2 No
<u> </u>	G S	To Be	examiner?	lospital: Inpatient	2 ER/Outpatie	ent 3 DOA Ot	her:		ence 6 □Other (Sp	ecify)
	ding Ph J. After th funeral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	/ear) 28b. Time Injury	of 28c. Inju	ury at 2 ork?	28d. Describe ho	ow injury occurred	
Sio	or Attending ifter death. Director: After in by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be				]Yes 2□No			
Division	or At ifter d Direct in by	Certification:	4 Homicide determined	28e. Place of injury building, etc.	- At home, farm, si (Specify)	treet, factory, office	2	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
1	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying Phy	sician: To the best of	my knowledge, dea	th occurred at the t	time, date and place.	and due to the c	ause(s) and manner a	as stated.
	e Hoor	Medical	(Check only 2 ☐ Medical Exami one)	ner: On the basis of e and manner state		nvestigation, in my	opinion, death occurr	ed at the time, o	late and place, and du	ie to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0.00.01	MA		se number		9d. Date signed (Mor	
P.			M. Sari-	ara3i	(1-1)	124	8047		01/10	2009
R	10		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type	Print)	alenian	kune	120011011	2009 e MD 20852.
1	- 01									
	St	ate	31. Date filed (Month, Day, Year)	O. Flogistic	s Signature	7				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02593 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** РМ Goldie H. Hughes 2055 KN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner gream Kose la 6 Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 23, 1917 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2√ F 91 224-16-3072 North Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov Maryland Baltimore Baltimore Director 1 ☐ Yes 2 ☐ No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Essex Avenue 21221 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Vas Decedeni Ev Armed Forces? ☐Yes 2 XNo filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: White 3 XWidowed 4 ☐ Divorced "natural" Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be f O.T. Holton Bessie Kirby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 8 Deborah H. Ridenour -daughter 1006 Essex Avenue Baltimore, Maryland 21221 other 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages -Department of Important: If it any Injury or conce. Metropolitan Crematory 1/13/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ronalad v. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ation disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner DeMen. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated event), set Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an After this certificate has funeral director, page 2 of autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗖 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

mace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

04

22. Registrar's Signature

Uhn

5

31. Date filed (Month, Day, Year)

			For State of Maryland / Depar State of Maryland / Depar Registrar Cert	tificate of E			No.2009	02594
	Physicia	an	1. Decedent's Name (First, Middle, Last)  John W. Holten, Jr.				Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	January	13 2009 4c. County of Death	
. do. of			Montgomery General Hospital  5. Social Security Number 6. Sex 7. Mge (In yrs. last birthday)	O Inty	If Under 24 Hrs.	8. Date of Birth	Montgomer	1 1
	Funeral Director		492-30-2916 1XM 2□F 78 Yrs.	Months Days	Hours Min.	(Month, Day, Ye	1930 Miss	olace (State or Foreign htry) ouri
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	ation			1	0d. Inside City Limits
	e Mary Ba-f sh	ctor	Maryland Montgomery Rockvill					1 □Yes 2 No
	th with th	Funeral Director	10e. Street and Number 14202 Castaway Drive	10f. Zip Code 2085	3		Citizen of What Cour	
920	should be filed within 72 hours after death with the Maryland and Mental Hyglene.  marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show matic event, the Ne Item Examirer must be notified at	ρ	1 Never Married 2 Married 1 Payes 2 No	las Decedent of Hi Yes, specify Cubar □Yes 2∏X No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	sify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: Wh:	etc.
Maryland 21215-0036	within 72 ho iene. than "natu ne Medical	Completed	(Specify only highest grade completed)    Elementary/Secondary (0-12)   College (1-4or 5+)   Inter	ent's Usual Occupa ind of work done d O NOT use retired national Officer	ation furing most of working Affairs	g Fo	o. Kind of Business/In ood and Dr dministrat	ug
nd 2	e filed al Hygi I other vent, I	Be C	17. Father's Name (First, Middle, Last)	OTT TO THE	18. Mother's Name	(First, Middle, Maid		
ryla	hould but Meni	ဥ	John W. Holten  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing	Address (Street :		ostello	ity or Town, State, Zip	Code)
, Na	1 and 2 should be Health and Mental em 27 Is marked o ther traumatic eve		John Holten, III (Son) 11928	Bayswat	er Road,	Gaithers	burg, MD 2	0878
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic es once.		4 □ Donation 5 □ Other (Specify) Cemete	e <sup>to</sup> heaven Prv	Janua Janua ss of Facility DeV	ry 17,	Location - City or To	
Ba	permi Depa Impo any ii						hersburg,	MD 20877
1	Physician		23a Part 1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.  Immediate Lause (Final disease condition	r the mode of dying	g, such as cardiac or			Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	rena	falluce			
	ed	iner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 61	1			
o,	tificate be executed g physician and as the burial-transit	I Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	P bleed	<u> </u>			
68760	ificate by physic is the b	edical	d					
P.O. Box	eath cer attendin for use	Physician/M		Ectopic pregnancy Other (specify)	у		23d. Date of deliv Month	ery Day Year
<u>റ</u> റ	e law requires that the d has been signed by the je 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause give	en in Part I.		co use contribute to t	he cause of death?
Corc	w requi	leted	A f.h			24a. Was an		opsy findings available
Vital Records,	hysician: The la his certificate had I director, page 2	Completed	7.10			autopsy performed 1 □ Yes 2	d?   death?	mpletion of cause of
Vita	siclan s certifi irector,	B	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	Othe	26. Place of Death		e 6 □Other (Speci	64)
Division of	nding Phy ath. r: After this e funeral d	ation: To	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury	28c. Injury Work	y at 2	8d. Describe how i		
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	e Hospil 124 hour e Funer letely fill	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death 2  Medical Examiner: On the basis of examination and/or investigation of the basis of examination and/or investigation.					
		Me	29b. Signature and title of certifier	29c. License	e number	1	Date signed (Month,	
	4+1		30. Name and address of person who completed cause of death (Item 23a) (Type, P	Print) Bichhu	01114	1	anuary 12	4 2004
			18101 Prince Philip Dr., Olney, M		832	, 11.0.		
	Sta Registi		31. Date filed (Month, Day, Year)  33. Registrar's Signature.	and .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1420 Arthur Alexander Harper 04 2009 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Heartland Healthcare of Hyattsville Hyattsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 76 1932 New Jersey March 02, Director 068-26-0508 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County District of 1 X Yes 2 No Director Washington Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 U.S.A. 1423 Sheridan Street NW, Apt. #B-1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ∑Yes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 🖾 No Specify ģ 3 ☐ Widowed 4 ☒ Divorced B1ack Korean Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Repairs 12 Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Lloyd Belvin Harper ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1251 Raymond Way, Charleston, South Carolina 29407 Sylvester R. Harper - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 01/14/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904 11800 New Hampshire Avenue, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cardiorespiratory Arrest /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Myocardial Infarction Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Coronary Artery Disease Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Atherosclerosis IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Extensive Cerebrovascular Accident Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autops, perlormed: 2 No 2 🗆 No 1 Yes 1 ☐ Yes Chronic Renal Failure Stages 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 🖾 Nursing Home 5 🗋 Residence 6 🗎 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

1 gratis

31. Date filed (Month, Day, Year) State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

Oney Zuniga, M.D.,

15

4701 Randolph Road, #216, Rockville, Maryland 20852

D47867

January 6, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

02596

29d. Date signed (Month, Day, Year)

1 - State Registrar **Physician** /Medical Examiner **Funeral** Director Director death

ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at filed within 7 Hygiene. 12 should be filed with and Mental Hygier
7 is marked other th

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

**Physician** /Medical Examiner

of Health

Department of Hear Important: If itemany International Int

burial-transit attending physician the use as ō the detached signed by t I be detach page 2 should peen has certificate director, this funeral After t

The law requires that the death certificate be executed Physician/Medical ospital or Attending Physician; hours after death. Be Certification: To Vo the Hospina. ...
within 24 hours after death.
To the Funeral Director: Af Medical

Month 01/11/2009 1:47РМ Miriam Geneva Hall 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 02/19/1925 9. Birthplace (State or Foreign Country)
PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Min. Davs Hours 215-20-4003 83 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 1 ☐ Yes 2X No MD Gambrills Anne Arundel 10e Street and Number 10g. Citizen of What Country? 1730 Underwood Rd. 21054-1828 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify. Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator ceramics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roy Samuel Kefauver Erma Cartee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code2110819a. Informant's Name/Relationship (Type. Print) 910 Courtland Manor Rd., Millersville, MD Linda Schreirer (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buria 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (\$pecify) Reformed cemetery: 01/16/2009Middletown, MD 21. Signature of Fundal Survice 22. Name and Address of Facility
Donald B. Thompson Funeral Home
POB 18, Middletown, MD 21769 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, from leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 22 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2/No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗔 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifie

30. Name and address of per-

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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F-17)

O

29c. License number

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 02597 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:00 Am 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hresda montgomery 8. Date of Birth (Month, Day, 1) JAN 11 Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Social Security Number 1 1933 **Funeral** Months Days Hours Min. 1 M 2 □ F SC 76 251-46-2250 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the rigitled at 1 Yes 2 □ No Director POOLESVILLE MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20837 USA 16904 HOSKINSON RD. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1953 -14. Race - American Indian. 11 Marital Status Armed Forces? 1 XYes 2 □ No 19 If Yes, Give 1955 Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify WHITE 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEULAH LONG LUTHER HARE ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CYNTHIA HECKER / DAUGHTER 16904 HOSKINSON RD., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition TRINITY MEMORIAL 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/17/09 WALDORF, MD 4 Donation 5 DOther (Specify) GARDENS 21. Signature of Englad Selvice Lio nsee HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lst only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 24 Physician CARDIAC FAILURE hrs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed signed by the attending physician and it be detached for use as the burial-tran Due to (or as a consequence of): sion of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death
Natural 28b. Time of 28d, Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No death. or Attendate after death Director: / the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled in 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 14, 2009 Western ela. D52451 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD P.O. MICHAEL Α. WESTERMAN BOX 2316, KENSINGTON, MD20891-2316 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State ank. 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** izab 2009 ola /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Med. Ctr. Salisbur eninsula Kegional If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) March 24, 1941 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖫 F Hours Months Days Min 40-7646 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expanditure rust be muffled at once. Crisfield 1 Yes 2 □ No Director SomerseT Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. A Cove 21817 omers Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black If Yes, Give Year or Dates: ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Seafood Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17th grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SR. tields Hlice Zora ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , md. Cristield Somers cove Sterling 31 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hope well U.M.C. cometer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Ineral 22. Name and Address of Ficility 23a. Part 1. Enfer the disease, or complications that caused the death, no not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Princess Anne MD 21803 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transi Exami Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for Ö 9 Unknown 9 Unknown ۵. significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation To the Hospius C. within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 296. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

100

PRMC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 10:00 AM January Louis Emmanuel Hansen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Voar 1**X** M 2 □ F 1926 New York Director Dec 12 118-20-6129 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ?? Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Wedcal Exertions. 1 ☐ Yes 2 No Director Gaithersburg MD Montgomery 10g. Citizen of What Country? 10e. Street and Number USA 11920 Fernshire Road 20878 death Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural". or incorrect any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: 1 0 / 1/1 □ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 2 3 ☑ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fire Fighter New York Fire Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leoneal LaFrank ೭ Louis Hansen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11920 Fernshire Rd. Gaithersburg, MD 20878 Evelyn Hansen/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 01/20/09 Odenton, MD Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature Funeral Service L us 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of): **Examiner** Lung Cancer Sequentially list conditions, if any, leading to him edial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence offi Examine sician and burial-transit b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) . 2. No Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Wadar D67512 January 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madan Bangalore, M.D. 9901 Medical Center Drive Rockville, MD 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN20 parke Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jan. 2009 10:10 A M Dennis R. Honchar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City
Under 1 Year | If Under 24 Hrs
onths | Days | Hours | Min. Howard 4017 High Point Rd. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X**2XM 2 □ F 219-36-1087 66 Director 2-26-1942 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director MD Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4017 High Point Rd. 21042 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withii Hygiene. Mechanical and Cemical Engr. Engineering is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ John Honchar Mary Kochenash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JoAnn Honchar / Wife 4017 High Point Rd., Ellicott City, MD 21042 Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages . 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 1-21-2009 Ardent Cremation Hanover, MD 22. Name and Address of FacilityHarry H. Witzke's Family FH, Inc. 21. Signature of Funeral Service Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last City to for as a consequency of Examine death certificate be executed burial-tran and Due to (or as a consequence of): physician Physician/Medical the ! as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No ģ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed? e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗖 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Division or Vital Records,

Box 68760

P.0.

Baltimore, Maryland 21215-0036

within 24 (E)22

State Registrar

eted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

30. Name and address of person who complete

31. Date filed (Month

JAN 2

29b. Signature and title of certifier

Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Lanham

4b. City, Town, or Location of Death

Jany de

4c. County of Death

Physician /Medical Examiner For State Registrar

Landonia Jones

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

**Funeral** Director

with the Maryland 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, The "sedical Expresses Trausi be notified at 23a hours after death

Baltimore, Maryland 21215-0036 n and Mental Hygiene. is marked other than "natural", or and 2 should be filed within 72 ! permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is
any injury or other trau **Physician** 

/Medical

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760, P.O. signed by the a Division of Vital Records, page 2 s has certificate this After To the Hospital or Attending death. Director:

If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Min. Days 1 □ M 2 🖾 F Months Hours 99 578-62-1421 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State Director DC n/a Washington 10e. Street and Number 10f. Zip Code 4105 Illinois Avenue 20011 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 21K No Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Obed Madden Landonia Stokes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #6013601 Connecticut Avenue, Leonade Jones / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 1/31/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive Heart Failure disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 1 X Natural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D23743 antr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin D. Weltz 7525 Greenway Center Drive, Greenbelt, MD

Prince Georges Date of Birth (Month, Day, Year) 5/31/1909 Birthplace (State or Foreign Country) Virginia 10d. Inside City Limits 1 AYes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Specify: Black 16b. Kind of Business/Industry DC Health Department NW Washington, DC 20008 20c. Location - City or Town, State Silver Spring, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🏝 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 TYes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 1/12/09 20770

Registrar

State

31. Date filed (Month, Day, Year)

filled in by within 24 hours after To the Funeral Direct

. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Year Month KATHLEEN Α. JONES 13, 2:35 P M JAN. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 220-58-5236 58 13, 1950 WASH. Usual Residence of Decedent with the Maryland 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experience was be notified at Director 1 X Yes 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? Funeral 718 THAYER AVE 20910 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent L. Armed Forces? 1 □Yes 2 No 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give 25 Year or Dates: Specify: à Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 show.

If Health and Mental hyseram 27 is marked other there is marked other the image. ADMINISTRATOR CHILD CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ MORRIS JONES FRANCES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT STAEHLE/HUSBAND 718 THAYER AVE., SILVER SPRING, MD. 20910 injury or other Department of Heal Important: If Item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-15-2009 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. - Chambure 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician MYELODYSPLASIA disease or condition resulting in death) 18 MONTHS /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit be executed NEUTROPENIA Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: f yes, outcome of pregnancy □ □ Live birth 2 □ Fetal death □ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 1 ☐ Yes 2 🔀 No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, THROMBOCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed ANEMIA certificate has be irector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Vital 1 □ Yes 2 X No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number selle D0059244 JAN. 14, 2009 30. Name and address of person who completed cause of death (1em 2.14) Type, Print) GISELLE M. MERY, M.D. 4416 EAST WEST HIGHWAY, BETHESDA, MD, 20814 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 15 Registra

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Jan. 2009 11:35 a<sup>M</sup> Patrick Jean-Julien /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 19320 Poinsetta Court Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday)
51 vrs Social Security Number **Funeral** 11/20/1957 1X M 2 □ F Haiti 217-82-3591 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d, Inside City Limits 10c. City, Town or Location t be notified at 10a. State 10b. County 1 X Yes 2 No MD Director Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a ( 19320 Poinsetta Court 20879 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Private Computer Technician permit. Pages 1 and 2 should be filk.
Department of Health and Mental Hy, Important: If Item 27 Is marked other any Injury or other traumatic. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pierre Kainer Jean-Julien Bernadotte Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlo Glaudin / Brother 4303 Elizabeth St., Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/15/09 Beltsville, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Instre! 7400 Georgia Ave., N.W., Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Immediate **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit be executed Box 68760, 45 Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | sate has been signed by the a page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 Hypertension 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hyperlipidemia 24a. Was an autopsy performe Hyperglycemia 1 Yes 2 X No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1KN Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred r Attending P er death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0068078 - 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registra

15

31. Date filed (Month, Day, Year)



09-00639
Claude Phillip Jackson

Please Type or Print in Black Indelible Ink 9 Ensure/All Capies Are Legible.
Amend Trem per spouse spouse State of Maryland Department of Health and Mental Hygiene 2009 02604

Funeral Director  Funeral Director  Funeral Director  All Dodge Park Road Apt. 301  Funeral Director	County of Death nce George's  D/YYYY) 9. Birthplace (State or Foreign Country)  Halifax, VA   10d. Inside City Limits 1 XYes 2 No  on of Whar Country?  Led States 4. Race - American Indian, Black, White, etc.  pecify: Black and of Business/Industry  OVERNMENT
### Funeral Director    Age   Facility Name (if not institution, give street and number)   3411 Dodge Park Road Apt. 301   4c. City, Town, or Location of Death   4c. City   Town, or Location of Death   4c. City   Town, or Location of Death   4c. City   Town, or Location of Death   4c. City   Town, or Location   County of Death nnce George's  D/YYYY) 9. Birthplace (State or Foreign Country)  Halifax, VA  10d. Inside City Limits 1 XYes 2 No on of What Country?  Led States 4. Race - American Indian, Black, White, etc.  pecify: Black nd of Business/Industry  Vernment	
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Director    Page 17   Page 2   Page 2   Page 2   Page 2   Page 2   Page 3	Halifax, VA  10d. Inside City Limits 1 XYes 2 No In of Whar Country?  Led States 4. Race - American Indian, Black, White, etc.  Pecify: Black and of Business/Industry  EVERNMENT
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Maryland Prince George's Landover    10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10e. Street and Number   10f. Zip Code   10g. Citizen   10f. Zip Code	1 XYes 2 No n of Whar Country?  ed States 4. Race - American Indian, Black, White, etc.  pecify: Black and of Business/Industry  overnment
3411 Dodge Park Road # 301  12. Was Decedent Ever in U.S.  Armed Forces?  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-  14. Marital Status  1 Never Married 2 Married  3 Widowed + Divorced  1 Never Married 2 Married  3 Widowed + Divorced  1 Never Married 2 Married  1 Never Ma	n of Whar Country?  ed States 4. Race - American Indian, Black, White, etc.  pecify: Black Ind of Business/Industry  Overnment
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	ocation - City or Town, State
Be a second seco	xandria, VA
201. Method of Disposition    202. Method of Disposition   1   Burial   2   X   Cremation   3   Removal from State   202. Mare of Disposition (Name of Cernetery, crematory or other place)   1   203. Method of Disposition (Name of Cernetery, crematory or other place)   1   204. Method of Disposition (Name of Cernetery, crematory or other place)   1   205. Local Control of Disposition (Name of Cernetery, crematory or other place)   1   205. Local Cernetery   1   205. Local Cernetery   1   206. Local Cernetery   206. Local Cerner	omes, P.A.
5538 mariboro Pike Forestvili	e, Maryland 20747 k, or heart   Approximate Interval
/Medical failure. List only one cause on each line.	Between Onset and Death
taminer Immediate Cause (Final disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	
Sequentially list conditions, b	
if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
To the second of	
XUNPENDED  AMENDED  A	
99 and 1	Date of delivery  Month Day Year
So the second the personal transfer of the second to the s	
The state of the s	se contribute to the cause of death?
	No 3 Probably 4 ✓ Unknown
	24b. Were autopsy findings available
Records,  The law require  To mpleted  Complete 2 should by  A Les 5 No  No  Selected 5	prior to completion of cause of death?
D = 2 so to to to medical   1	1 <b>Y</b> Yes 2 No
25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other, 4 Nursing Home 5 Residen	nce 6 ✓ Other: Scene
28b. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury	ry occurred
Solution of the second of the	
28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street an or Town, State) 34	d Number or Rural Route Number, City 411 Dodge Park Rd attsville, MD
Volume 1 of 1 of 1 of 1 of 1 of 1 of 1 of 1 o	
Notice the part of	I manner as stated. ce, and due to the cause(s)
Check only 1 (Check only 1 (Ch	Pate signed (Month, Day, Year)
	ary 22, 2009
30. Name and address of person who completed cause of death (Item 23a)	
Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day Year) 32. Registre & Signal re	

State of Maryland / Department of Health and Mental Hygienes 02605 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Lillian Etta KENDLE 11:00 a<sup>M</sup> January 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Somerford Place Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🕱 F 81 219-20-2106 Director June 6, 1927 Maryland Usual Residence of Decedent 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Medical Exprairate, aust be mutfilled at Director 1 Tx Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Church Street Funeral 21740 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: white 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, In. M. once. Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jim Bagley Vista White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4224 Fording Creek Rd., Greencastle, Pa. 17225 Katie M. Green - granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 1/23/09 4 ☐ Donation 5 ☐ Other (Specify) Sharpsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumon Dous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the. 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Month Year 5 Other (specify) P.O. 9 Unknown signed b I be deta Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate l 1 ☐ Yes 2 ☐ No 1 □Yes 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 HOther (Specify) 455,15140 1 Yes 2√No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? INMA or Attending 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0-0056413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL CT HALERSTOWN, MD GH-5 SAXENA, MD NJAY 1138 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN22 Registrar A. park

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 02606 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ELSBETH **EMMA** KNUPPEL 10:00 AM JAN. 13,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death SHADY GROVE HOSPITAL ROCKVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F 216-50-9508 95 Director GERMANY Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location od other than "natural", or items 23a or 28a-f show event, the Modical Exar, incre, ust be retilied at 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE Director M☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married 2 X No , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER HOME OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN EMMA PERLITZ ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY KNUPPEL- SON 3243 JONES ROAD, WOODBINE, MD. 21797 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEM 1/17/2009 BRENTWOOD, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE.NW 21. Signature of Funeral Service Licensee W WASHINGTON, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** FAILURE EART disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner DEPSIS Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last OF THE LOWER EXTREMITES executed CELLULITIS burial-trar Due to (or as a consequence of) Box 68760 physician certificate be Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) P.0. the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate Division of Vital 2 XNo 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) I 🕎 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Aftert 28d. Describe how injury occurred 1 X Natural 5 Pending death. thin 24 hours after death.

the Funeral Director: A
pmpletely filled in by the ft. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) M.D lesce Doo68080 JAN.13,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIREESHA JALCI 9901 M.D ROCKVILLE MID MEDICAL LENTER DRIVE JAN 16 2009 (Month Day Year) State Registrar

Physician /Medical Examiner

**Funeral** Director

for State Registrar		State of Me		-	cate of				Reg. No	0.6	00	9	026	507
1. Decedent's Name	_							2. Date of De Month	ath Da	У	Year	3.	Time of Dea	ath
Yang		on Kim						Jan.6	,20	09			8:45	p <sup>M</sup>
		give street and number)			City, Town, or				40	. County				
5. Social Security N	Olph Hi	lls Nursi	ng Home (In yrs. last bird	e thday) If U	Wheat Under 1 Year	on If Under	24 Hrs.	8. Date of Birt	th	Mon	t go	mer	State or Fo	oreian
214-25-7 Usual Residence of	7616	1□M 2 <b>⊠</b> F			nths Days	Hours	Min.	(Month, Da 5 1 2 2 /	1 9 2	23	Ko	rea	l	
10a. State	10b. County		10c. City, Towr									10d. In	side City L	imits
MD	MOntgo	mery	Roc	kvil	le							1	□Yes 2	No
10e. Street and Nu		ng Way		10	of. Zip Code	355			10g. Cit	tizen of V		untry?		
11. Marital Status	3024 112	12. Was Decedent	Ever in U.S.	13. Was I			igin? (Spe	cify Yes or No	-	14. Rac	e - Amer		dian,	
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced  1 □ Never Married 4 □ Divorced  1 □ Never Married 4 □ Divorced  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Ame Black, Whit											1			
		grade completed)		Decedent's (Give kind life. DO N	Usual Occup of work done o OT use retired	ation during mo	st of workin	ng	16b. K	ind of Bu	ısiness/l	Industry	,	
Elementary/Seco	ondary (0-12)	College (1-4or 5	+)		memake					)wn	Hom	ıe		
17. Father's Name	(First, Middle, La	ast)				18. Moth	er's Name	(First, Middle,	Maider	Surnam	ne)		· · · · · · · · · · · · · · · · · · ·	
Deok Ki	Lm					Sooi	n Gi	l Kim						
19a. Informant's Na Stella I				_				al Route Number y Rock	_			•	*	
	☐Cremation 3	☐Removal from State	20b. Place of cemeter	Disposition ry, cremator	(Name of ry or other place Heave	ce)	_	/2009		ocation -	-		State .ng, M	17
4 □ Donation 21. Signature of F	5 ☐ Other (Spe		Gac		ne and Addre	RTN	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	FUNEF	RAL	SER	VIC	E,P	. A.	
P / VL	ly NI	Crut		924	1 Colu	ımbia	a Bl	vd.Sil	ver	Sp	rin	ıg,M	id 20	190
Immediate Cause	(Final	omplications that caused by one cause on each lin		not enter the	e mode of dyir	ig, such as	s cardiac o	or respiratory a	rrest,			Inter Ons	roximate val Betwee et and Dea MO.	en .th
disease or condition resulting in death)	on (		agia a consequence ( imers										yrs.	
Sequentially list co if any, leading to in	enditions, nmediate	b	a consequence		35e									
Cause (Disease or that initiated events resulting in death)	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Anxiety with panic disorder  c. Due to (or as a consequence of):									yrs.				
			itis o	•	ltiple	jo:	int		-			2 у	rs.	
IF FEMALE:									T		i			
23b. Was deceden in the past 12 1 ☐ Yes 23 9 ☐ Unknown	months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		opic pregnancy er <i>(specify)</i>	′				23d. Dat Mo	te of deli nth	ivery Day	Yea	r
Part II. Other signi	ficant condition	s contributing to death b	ut not resulting in	the underly	ying cause giv	en in Part	l.	23e. Did t	obacco	use cont	ribute to	the cau	use of deat	h?
								10	Yes 2	ĭXNo	3 ☐ Pr	obably	4 □Unkı	nown
								24a. Was autop			Were au prior to o death?	itopsy fi complet	ndings avai	ilable e of
25. Was case refer	rrad to madical					00 5:	f D - 1"	1□ Yes	2 <b>X</b> No		1 ☐ Yes	2	No	
examiner?		Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Ou	tnatient 2	□ DOA Oth	or:		n <i>(Check only o</i> me 5 ☐ Resi		6 DO#	or /Car	oifu)		
27. Manner of Deat	th 5 ∏Pending	28a. Date of Inju (Month, Da	ry 28b. 7	Time of njury	28c. Injur Wor	y at k?	2	28d. Describe				city)		
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigat 6 □ Could no determina	t be 280 Place of init	ury - At home, fa c. (Specify)	rm, street, f		Yes 2□		28f. Location (S City or Tox	Street a	nd Numb e)	er or Ru	ıral Rou	te Number	,
29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best caminer: On the basis o and manner sta	f examination an	e, death occ d/or investi	urred at the tir gation, in my o	me, date a opinion, de	ind place, a	and due to the red at the time,	cause(s	s) and ma	anner as and due	stated.	cause(s)	
29b. Signature and	title of certifier	and mariner sta			29c. Licens	e number			29d. Da	ate signe	d (Montl	h, Day,	Year)	
D0021033 Jan.8,2009										,				
_	ress of person w	no completed cause of d				Cil	₹70.30	Cnri-	~ ^*	a 2	000	<i>c</i>		
31. Date filed (Mor		Tiogloti.	000 Ge ar's Signature	orgia	A LAVE.	ונס	ver	<u>əprin</u>	<del>g,</del> M	a 2	<del>u 9 ()</del>	<del>b</del>		
JA	MIDS	100 Seren	1 13.14	TO THE										

State Registrar

			1 - For State Registrar	State of M	ai yiai iu	Cer	rtificate of	Death	a Mental F	Reg. 1	<sup>1e</sup> 2009	02608
	Physici	an	1. Decedent's Name (First, Middle, L	1					2. Date of Month		Day Year	3. Time of Death
	/Medic		Mariann Kay Kur			Janua		4, 2009	11:35 P <sup>M</sup>			
	Examin	er	4a. Facility Name (If not institution, g	ive street and number,			or Location of De	4c. County of Deat				
	F		Casey House  5. Social Security Number 6.	Sex 7. Ac	je (In yrs. las	t birthday)	Rockvil If Under 1 Year	_	rs. 8 Date of	l <sup>v</sup> .	lontgomer	
	Funeral Director		505-74-8251 Usual Residence of Decedent	1□ M 2X F	50	Yrs.	Months Days			Day, Yea 2 , 1	.958 Neb	hplace (State or Foreign ountry) Yaska
	land ow	tor	10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	Mary		MD Montgome	rv	Silve	er Sp:	ring					1 □ Yes 2 No
	th the	jrec	10e. Street and Number	J			10f. Zip Code			10g.	Citizen of What Co	untry?
	th will	la I	8716 Plymouth St	eet #5			20901			US	A	
	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hyglene.  ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be rediffied at its.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ∐Yes 2X		13. V	Was Decedent of f Yes, specify Cub	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or erto Rican, etc.)	No-	14. Race - Ame Black, White	
21215-0036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I∐Yes 2∭∑No	Specify:			Specify: Wh	ite
5-0	72 hor	eted	15. Decedent's l (Specify only highest g	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					16b.	Kind of Business/		
121	rithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or				ed)	voining	_		-
2	iled w Hygie ther t		17. Father's Name (First, Middle, Las	5+	1	Libra	rian	18 Mother's N	lame (First, Midd		ofession	al Assc.
Maryland	d be f ental ced or	) Be	Duane Kumke	4)					Mae Wit		,	
Z	2 should and Mer is marke aumatic	우	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	a Address (Stree				y or Town, State, 2	Zip Code)
	1 and 2 : Health a em 27 is		Judith Ann McCom									
re,	of Head		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name of natory or other pla	ice)	Date	20c.	Location - City or	Town, State
im	Page ment ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	」 Removal from State ify)		Arunde	el Crema	tory 01			enton, M	
Baltimore,	permit. Pages : Department of the important: If Ite any injury or of once.		21. Signature of Funeral Service Lice	to O. Ha	MO1251	22 G0	Name and Address	ess of Facility e Cremat	ion Ser	vice	P.O. B	ox 784 le, MD 21029
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	nplications that cause		Do not ente	er the mode of dy	ing, such as card	liac or respiratory	arrest,	Talksvii	Approximate Interval Between
			Immediate Cause (Final disease or condition	a. Metastat								Onset and Death
1	/Medical		resulting in death)	Due to (or as			ILCET					
	Examiner	ir	Sequentially list conditions,	b. Seizure								
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	nce of):						
,	execunate and all-train	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequen	nce of):						
68760,	cate be executed physician and the burial-transit	Medical	•	d								
	rtifica ng phy as th	<b>l</b> edi	15.55.111.5									
Вох	eath cer attendin for use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnan	cy			23d. Date of del	
P.O. E	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months? 1 □ Yes 2  No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of dear		Other (specify) _			-	Month	Day Year
	ned by deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the un	nderlying cause gi	ven in Part I.	23e. Di	d tobacc	o use contribute to	the cause of death?
rds	w requires s been sign should be								_ 10	Yes	2 □ No 3 □ Pr	obably 4 🗆 Unknown
of Vital Records,	e law re has ber re 2 sho	Completed			_				24a. Wa	as an topsy	24b. Were au	topsy findings available completion of cause of
<u> </u>	The cate has page	Com							pe 1 □ Yes	rformed?	death?	2 □No
/ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Llacarita la			lau		eath (Check onl			
of	Phys this	٦.	1 ☐ Yes 2 ☐No  27. Manner of Death	Hospital: 1 ☐ Inpati	ent 2 ER	R/Outpatien Bb. Time of	I JUDON					hospice
ou	ding n. After funer	tion	1X Natural 5 ☐ Pending	(Month, Da	y, Year)	Injury	28c. Inju Wo	rk? ]Yes 2∐No	280. Describ	e now in	jury occurred	
Division	or Attending after death. Director: After I in by the funer	fica	3 ☐ Suicide 6 ☐ Could not	28e. Place of Ini	ury - At home	e, farm, stre	eet, factory, office		28f. Location	(Street	and Number or Ru	ıral Route Number,
Ö	tal or s after at Dire	Certification:	4 ☐ Homicide determine	building, et	c. (Specify)				City or 1	own, Sta	ate)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical	29a. Certifier 1 ☐ Certifying F (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	edge, death n and/or inv	occurred at the t restigation, in my	ime, date and pla opinion, death o	ace, and due to t ccurred at the tim	he cause e, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. Licens		2	29d. [	Date signed (Monti	n, Day, Year)
			> Jocelyne	KOUATC	HOLLI	mD	Dec	6374	8	Jan	uary 15,	2009
	6)02		30. Name and address of person who Jocelyne Kouatch	ou, M.D. 60	001 Mur	ncaste	er Mill 1	Rd. Rock	wille, l	MD 2	0855	
	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Régistr	ar's Signature	B. 4	arkil		<u> </u>			

Physician
/Medical
Examiner

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Physic /Medi Exami

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

1	For State Registrar	e /First Middle	e /asti			(	Certifica	ate of	Death	2. Date		<u>. 20</u>	09	0260 3. Time of Death						
	JOAN	s (i iist, iviidale	M .				KENI	EALY	1	Janua	D D	ay 2	Year	2330 PM						
4a	. Facility Name (If		-		ber)		4b. C	ity, Town, o	r Location of Deat			c. County								
	he Johns Social Security N		6. Sex	oital	7 Ago /in	yrs. last birth		Itimore		8. Date of	of Birth	NC	NE	place (State or Foreig						
	18-28-68			2000F	7. Age (III)		Mont		Hours Min.		3 <u>-</u> 1932	2	MD	ntry)						
-	sual Residence of	Decedent 10b. County			100	. City, Town	or Location							10d. Inside City Limit						
		Howard				licot		7						1 ☐ Yes 2004N						
	e. Street and Nur		<b>u</b>			111000		Zip-Code			10g. C	itizen of W	hat Cour	ntry?						
	226 Wind	ing Wa	У					1043			USA	<i>A</i>								
11	. Marital Status	ed 2 Ne-		Was Dece Armed For 1 ☐ Yes	rces?	n U.S.	13. Was De If Yes, s	ecedent of specify Cub	Hispanic Origin? (S an, Mexican, Puerl	specify Yes on Rican, etc.	r No- .)		e - Amerio k, White,	can Indian, etc.						
	Widowed			If Yes, Give Year or Da	е		1 ☐ Ye	s <b>XX</b> No	Specify:			Specify	Whi	.te						
	(Spec	15. Deceden						work done	during most of wo	rking	16b.	Kind of Bu	usiness/Ir	ndustry						
-	Elementary/Seco	ondary (0-12)		College (1-	4 or 5+)		iife. DO NO emake:	T use retire			OK.77	n Hom	P							
17	12 '. Father's Name (		Last)			IDOIL	chare.	L-	18. Mother's Na	me (First, M										
	rank P.								Hilda E	. Mat	oska									
19	a Informant's Na				ightei				wand Number or R Way, Ell											
20	a. Method of Disp		3 □ Per	oval from 9		Ob. Place of cemetery	Disposition crematory	(Name of or other pla	ce)	Date		Location -	City or To	own, State						
	4 Donation	5 Other (S	pecify)		I	Ardent	Crema	ation		-2009		nover								
21	21. Signatule of Funeral Service Livensee MO1411  22. Name and Address of Facility Harry H. Witzke's Family F. F. 4112 Old Columbia Pike, Ellicott City, MD 23																			
23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betwee														Approximate						
Im	shock, or hear nmediate Cause (	t failure. List Final	only one o	ause on ea	ach line.	icil	aV 7	. 1						Onset and Death						
Immediate Cause (Final disease or condition resulting in death)  Onset and O																				
bue to (or as a consequence of).																				
if if if if if if if if if if if if if i	equentially list cor any, leading to im ause. Enter Unde ause (Disease or	mediate rlying injury	₹	Due to	or as a cor	nsequence o	t):													
th	at initiated events esulting in death)	3	C	Due to	or as a cor	nsequence o	f):													
			d																	
IF	FEMALE:									•										
23	3b. Was decedent in the past 12	months?	23c		oirth 2	Fetal death			cy .				te of deliv	very Day Year						
200. Was decedent program   1   Live high 2   Established Programmy																				
	art II. Other signi	ficant conditi	ons contri	buting to d	eath but no	ot resulting in	the underly	ing cause	given in Part I.	23e.	Did tobacc	o use cont	tribute to	the cause of death?						
	<del></del>										1 🗌 Yes	2 No	3 🗌 Pro	bably 4 🗌 Unknow						
Pa										24a.	Was an autopsy		prior to c	opsy findings available ompletion of cause of						
Pa										1 🗆	$\overline{}$	No	death? 1  Yes	24 No						
									26. Place of De			6 - 0	or /Sees	(6 <sub>1</sub> )						
25	5. Was case referrexaminer?	1		spital:	innations	2	nationt of	I DOM I OT	with the property of the party	IOTHE D	i residence									
25	examiner? 1  Yes 2	No th	Hos	28a. Date	of Injury		ime of	28c. Inju	ry at	28d. Desc	cribe how in	july occur								
25	examiner? 1  Yes 2  7. Manner of Deat 1 Natural 2  Accident	No th 5 □ Pendir investi	Hos ng gation	28a. Date		28b. T	ime of njury	28c. Inju	ry at rk?	28d. Desc	cribe how in	jury occum		_						
25	examiner? 1  Yes 2 7. Manner of Deat 1 Natural	No th 5 □ Pendir	Hos ng gation not be	28a. Date (Mont	of Injury h, Day Yea	28b. T ir	ime of njury M	28c. Inju	ry at rk?	28f. Loca		end Numb	oer or Ru	ral Route Number,						
255	examiner? 1  Yes 2  7. Manner of Deat 1  Natural 2  Accident 3  Suicide	No th 5 Pendir investi 6 Could detern	ng gation not be nined	28a. Date of (Mont) 28e. Place buildi ian: To the property of the british for	of Injury h, Day Year of injury - r ng, etc. (Sp	28b. T in At home, far hecify)	ime of njury M m, street, fac	28c. Inju Wo	ry at rk?	28f. Loca City o	tion (Street or Town, Sta	end Numb	anner as	stated.						
25	examiner? 1   Yes 2 7. Manner of Deat 1   Natural 2   Accident 3   Suicide 4   Homicide 9a. Certifier (check only)	No  th 5 Pendir investi 6 Could detern  Certifyii 2 Medical	ng gation not be nined	28a. Date of (Mont) 28e. Place buildi ian: To the property of the british for	of Injury th, Day Year of Injury of Injury ng, etc. (Sp best of my asis of exam	28b. T in At home, far hecify)	ime of njury M m, street, fac	28c. Inju Wc 1 Correct at the rectant in my 29c. Licen	ry at rk?  Jes 2 No  No  Mee, date and place opinion, death occurrence number	28f. Loca City of the and due courred at the	tion (Street or Town, Sta to the cause time, date :	end Numb te)	anner as and due	stated. to the cause(s)  Day, Year)						
25	examiner? 1   Yes 2 7. Manner of Deat 1   Natural 2   Accident 3   Suicide 4   Homicide 9a. Certifier (check only one)	No  th 5 Pendir investi 6 Could detern  Certifyii 2 Medical	ng gation not be nined	28a. Date of (Mont) 28e. Place buildi ian: To the property of the british for	of Injury th, Day Year of Injury of Injury ng, etc. (Sp best of my asis of exam	28b. T in At home, far hecify)	ime of njury M m, street, fac	28c. Inju Wc 1 Correct at the rectant in my 29c. Licen	ry at rk?   Yes 2 \sum No	28f. Loca City of the and due courred at the	tion (Street or Town, Sta to the cause time, date :	end Numb te) s(s) and ma and place,	anner as and due	stated. to the cause(s)						
25 29 30	examiner? 1   Yes 2 7. Manner of Deat 1   Natural 2   Accident 3   Suicide 4   Homicide 9a. Certifier (check only one)	No  5 Pendir investi 6 Could detern  Certifyli 2 Medical	ng gation not be nined	28e. Place buildi	of Injury  th, Day Year  of injury - th  ng, etc. (Sp  best of my  asis of examer stated.	28b. T ir At home, far pecify) knowledge, mination and	ime of njury M m, street, factoristic death occurring investigation.	28c. Inju Wc 1 Correct at the rectant in my 29c. Licen	ry at rk?   Yes 2 \sum No	28f. Loca City of De, and due courred at the	tion (Street or Town, Sta to the cause time, date at	end Numb (e) and mand place,	anner as and due	stated. to the cause(s)  Day, Year)						

Division of Vital Records, within 24 hours a

> Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Krishan Mathur, M.D. P.O. Box 2729 LaPlata, Maryland

32. Registrar's Signature

29c. License number

D28352

29d. Date signed (Month, Day, Year)

January 12, 2009

State of Maryland / Department of Health and Mental Hygiene 02611 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Francis Leonard Lusby 2009 9:13 a /Medical January 13. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F **Director** 579-35-3330 78 1930 Washington, May 8, DC Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 Is marked other than "natural", or items 23a or 28a-f shoi traumatic event, The Modical Evan 1 ☐ Yes 2 → No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number Funeral 2110 Dexter Avenue, Apt. 102 20902 r death USA permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural". or itemany injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1★]Yes 2 □ No If Yes, Give Year or Dates: 1951- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2x No Specify. ð 3 Widowed 4 Divorced 1951-53 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Financial Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Arthur Lusby, Sr. Kathryn Gertrude Leonard ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 521 Vichy Hills Drive, Ukiah, CA 95482 William A. Lusby/Brother Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan. 16, **X**Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd., W., Silver Spring MD 20001
rest, Approximate
Interval Between
Onset and Death blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one bause on each line. 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiorespiratory Arrest /Medical Due to (or as a consequence of): Examiner Multi Organ Failure
Due to (oras a consequence of): Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transi Acute Renal Failure Due to (or as a consequence of) Box 68760, aftending physician for use as the burial Physician/Medical Metastatic Liver Lesions IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, cate has been si, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an Hospital or Attending Physician: The L24 hours after death.
Funeral Director: After this certificate ha 1 ☐ Yes 2 🕱 No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a completely filled 1 🕰 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) D68150 January 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nejib Siraj, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State JAN 15 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 14 / 2009 4:15A M Paul Lewis Lentz 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Braddock Hgts. Frederick Vindobona Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 050/262/1218 g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Indiana 303-18-8479 1**X** M 2 □ F 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Frederick Walkersville 1 ☐ Yes 2 ☐ XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10730 Dublin Rd. 21793 USA 12. Was Decedent Ever in U.S. Armed Forces? T.TT.T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 XYes 2 No WW If Yes, Give Year or Dates: Black White etc. 1 Never Married X Married 1 □Yes 21X No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) federal College (1-4or 5+) 5 + Elementary/Secondary (0-12) mycologist government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Stephenson Lentz Maude Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Paul S. Lentz (Son) 10730 Dublin Rd., Walkersville, MD 21793 01/1572009 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Smithsburg, MD 4 ☐ Domation 5 ☐ Other (Specify) Bonald B. Thompson Funeral Home Signature of Funeral Service dies c POB 18, Middletown, MD 21769 Approximate Interval Between Onset and Death 23 a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Severe disease or condition resulting in death) Due to (or as a consequence of MONITHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Th rive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician/Medical β Completed

Be

Certification: To

Examiner

attending physician and for use as the burial-tran signed by the director, page 2 should peen has After this certificate funeral

**Physician** 

/Medical

Director

Funeral

Completed

Be

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Micdical Examiner must be notified at

72 hours after death

filed within 7 I Hygiene.

pe

Pages 1 and 2 should

Department of Health and Mental Hygiene Important: If item 27 is marked other than "any injury or other traumatic event, it is Market in the M

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

Physician: The law requires that the death certificate be executed ospital or Attending hours after death. To the Hospital or Autorial within 24 hours after death.

To the Funeral Director: Aft

Medical State Registrar

29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRAYEEN BOLARUY, MD

(Check only one)

29a. Certifier

31. Date filed (Month, Day, Year) 6

and manner stated.

\$2. Registrar's Signature

1967 Drive, SUITE# 225, FREDEUCE, TO 4702

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

00062223

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	laryland		artment rtificate			and M	ental Hy	giene Reg. N2	009	0 2	261	3
X	Physici	án	1. Decedent's Name (First, Middle, Last					-			2. Date of De Month	Day	Yee		ime of Dea	ıth
	/Medic	cal	JACOB MELVIN LOAR		-1		4b Cib. 3	T	l continu	4 Denth	01	27	2009		:10P	М
	Examir	ier	4a. Facility Name (If not institution, give FROSTBURG VILLAGE			2		STBU	Location o	or Death			County of De LEGAN			
12.00	Funeral	€ ~	5. Social Security Number 6. Se	x 7. A	ge (In yrs. las		If Under Months	1 Year	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. B	irthplace (5	State or For	reign
×	Director		213-16-406/	<b>Q</b> M 2□F	86	Yrs.	MOHUIS	Days	Hours	MIII.	03 10	192	22 MAT	RYLANI	)	
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Ins	ide City Li	mits
	Marylan a-f show	tor	MD ALLEGA	NY	FRO	OSTBU	RG							1 (	Yes 2	Νo
	ith the M or 28a-f	Director	10e. Street and Number			9250	10f. Zip	Code				10g. Citiz	en of What (	Country?		
	ath w		19617 OLD MIDLOTH				215					U.S.				
36	J within 72 hours after death with the Maryland jiene. rthen "naturel", or Iteme 23a or 28a-f show tre Medical Examinat must be multied at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? ]No 1943		Was Deced f Yes, spec 1 ☐ Yes 2	1	spanic Orig , Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		4. Race - An Black, Wh Specify:		an,	
5-0036	72 hours naturel',		15. Decedent's Edu (Specify only highest grad				ient's Usua kind of wor			of worki	na	16b. Kir	nd of Busines			
2121	c * 6	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	e retired)	ining most	OI WOIKII	ng .					
2	filed w Hygiei other tl		17. Father's Name (First, Middle, Last)			TU	RE_BU			r's Name	(First, Middle		TRE			
au	ould be filed Mental Hyg arked other atic event,	To Be	JACOB LOAR								TKIN L		Jamamoj			
Maryland	S D E E	۲	19a. Informant's Name/Relationship (T)	rpe, Print)	17	19b. Mailin	g Address	(Street a			/ Route Numb		Town, State,	Zip Code)		
	s 1 and 2 of Health a item 27 is other tre		DIANA CUTTER D	AUGHTER					MIDLO		N, MD	2154	<b>.</b> 3			
Baltimore,	m O L		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	2000	ce of Disponetery, cren	sition (Nam natory or ot	ne of her place	) [	D	ate	20c. Loc	ation - City o	or Town, St	ate	
Iti m	그 돈 돈 글 .		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		FROS	STBURG					2009	FROST	BURG,	MD		
Ba	Depa fmpo	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  SOWERS FUNERAL HOM  60 W. MAIN ST, FROSTBURG, MD 21532  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										HOME, 532				
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each	line.		er the mode	of dying	, such as o	cardiac o	r respiratory a	rrest,		Interv	ximate al Betweer and Deatl	
8	Physician /Medical		disease or condition resulting in death)		s a consequer		End	5 tag	je	Ve	men	7a		6	mont	hs
	Examiner		Convention the lies and divine	b	2 2 3 3 1 1 2 3 3 3	.00 0.).										
1	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequer	nce of):										
ng.	be executed sicien end burial-transit	Examine		Due to (or a	s a consequer	nce of):								-		
8760,	e be e sicien e buria			,		,										
89	tificate ig physi as the l	ledic	~	J										<u> </u>		
Вох	The law requires that the death certificate be executed to has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcom 1 ☐ Live birth			Ectopic pre	gnancy				2	3d. Date of d	elivery Day	Year	
0	at the dea by the a tached f	ysic	1 Yes 2 No 9 Unknown	4☐Pregnant a 9☐ Unknown	at time of deat	th 5 □	Other (spe	ecify)					Wichiti	Say	7041	
, P.O	res that ti igned by be deta	by Ph	Part II. Other significant conditions con	ntributing to death	but not resulti	ng in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did t	obacco us	e contribute	lo the caus	e of death	1?
rds	w requires been sign should be										1 🗆	Yes 2□	]No 3□F	robably	4 JUnkn	own
Vital Records,	law requas been 2 should	Completed									24a. Was		24b. Were a	autopsy fine	dings availa	able
<u>=</u>	The la	Сош										rmed?	death?	40.00		O.
Vita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only					
o	Phys	: To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Ini	urv 28	VOutpatien  Bb. Time of		Α	4 Nur		ne 5 Resi			ecify)		
ion	stending I death. ctor: After y the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	м	3c. Injury Work′ 1 □ Y	? es 2□N							
Division	or Attendation death Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	ijury - At home tc. (Specify)	e, farm, stre	eet, factory,	office		2	8f. Location ( City or To		Number or F	Rural Route	Number,	
	To the Hospital or Attending Physicien: within 24 hours after death and To the Funerel Director: After this certifical completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Physical Examination	ner: On the basis	of examination	edge, death	occurred a	at the time	e, date and	d place, a	nd due to the ed at the time,	cause(s) a	and manner a place, and du	as stated. ue to the ca	use(s)	
	To the To the Complet	Med	29b. Signature and title of certifier	and manner s	14100-		29c.	License	number			29d. Date	signed (Mor	nth, Day, Y	ear)	
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	8	1			death (Item 23	3a) (Type, I	Print)		9						-	
	() Sta	to	31. Date filed (Month, Day, Year)	ompleted cause of 9.2.5 6.1 32. Regist	rar's Signatus	NHLS	n Ki	1 6	ungi	erla	nd h	1/2	-130	-		
N. C.	Registr		FEB 0 2 2009	anous	A. A	As Kon										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Grace M. Leibold Jan. 2009 1:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Catherine's Nursing Home Emmitsburg, Frederick If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year)
Feb 6, 1914 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F 057-09-2891 94 Brooklyn, NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at PA Adams Director Carroll Valley 1 ¥Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Carroll Trail 17320 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic d 2 should be filed w th and Mental Hygies 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florance McCarthy Agnes Savalaska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum Barbara Lowrie, Daughter 4 Carroll Trail, Fairfield, PA 17320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Northside Catholic Cemetery 1-27-09 Pittsburgh, PA 4 ☐ Donation 5 ☐ Other (Specify) 12525 Bradbury Ave 21. Signatu of Funeral Service License 22. Name and Address of Facility JL Davis Funeral Home Smithsburg, MD Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cause on each line. Approximate Interval Between Onset<sub>l</sub>and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical the SE attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown gignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 □ Yes 2/1 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 24 hours after death. 1 A Natural 2 Accident 5 Pending investigation Injury the Funeral Director: Af 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one)

State

Registrar

31. Date filed (Month, Day, Year) FEB 0 2 2009

Alan Carroll.

29b. Signature and title of certifie

310 S. Seton Ave., Emmitsburg, 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 the

Records, P.O. Box 68760,

**Division or Vital** 

29d. Date signed (Month. Dav. Year)

MD 21727

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 per ab 2893 7-15-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 02615 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** William Miller 2255 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University & Maryland Medical

Social Security Number 6. Sex 7. Age (In Baltomore Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Days Hours 215-78-6203 38 Director Oct 11, 1970 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r items 23a or 28a-f show Director 1 ☐Yes 2√ No MD Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11035 Hickory School Road 21795 Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the "Medical Exal. The Control of the Austral A 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Ragan Miller Virginia Lee Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 S. Greene Street Baltimore, MD University of Maryland Med Ctr permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5█Other (Specify) in state Sign ure Funeral rvice Licensee R. ald S. W. Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Profound hypotension Hours Sequentially list conditions, any, Laure Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed A hours affer death.

Euhoral Director: Affer this certificate has been signed by the attending physician and stelly filled in by the funneral director, page 2 should be detached for use as the burial-transit Urinary truit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Stroke Weeks IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 □XNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∭XYes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ★ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 90826504

Registrar
DHMH 17 Rev 1/2001

State

breine

22

Baltimore, MD

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

an

gistrar's Signature

61

Mazen

31. Date filed (Month, Day, Year)

			1 = For State Registrar	State of Ma			ent of F ate of		and Me	,	giene Reg. No.?	009	02616
	Physici		1. Decedent's Name (First, Middle, Las Sophia	<sup>t)</sup> Z.			Myers			. Date of Dea Januar		2009	3. Time of Death 2:40A. M
and the same of th	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. C		r Location of			4c. Cc	ntgomer	
	Funeral Director		5. Social Security Number 6. Social Security Number 1 Social Security N	ex □ м 2 【XTF 7. Age	e (In yrs. last birtho 91 Yr	Mont	der 1 Year ns Days	If Under Hours	Min. Fe	Date of Birtl (Month, Day eb.17,	1917	9. Birthp Cour New	olace (State or Foreign oftry) Jersey
	e Maryland a-f show	ctor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town o							1	0d. Inside City Limits 1 □Yes ※ No
	th with the 23a or 28	<b>Funeral Director</b>	10e. Street and Number 5225 Pooks Hill R	oad,#918N		10f.	Zip Code 208 <b>1</b>	4	- · ·		-	of What Coun ed Stat	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medicel Examinar must be nothed at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1	ever in U.S.		cedent of H pecify Cuba 2 XNo	ispanic Origin, Mexican Specify:		y Yes or No- can, etc.)		Race - Americ Black, White, e ecify:	
Baltimore, Maryland 21215-0036	within 72 ho liene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Housewife  own home										
/land	12 should be filed w h and Mental Hygie 7 Is marked other t raumatic event, In	To Be C	17. Father's Name (First, Middle, Last) Hayman Zəlkind						er's Name <i>(F</i> Potasl	First, Middle, I			<u></u>
e, Mari	1 and 2 sho Health and I em 27 Is ma ther traums		19a. Informant's Name/Relationship (7) Rhonda L. Kaufman	vpe. Print) -daughter	139	04 Wi	llow '	Tree	er or Rural R Drive	Rockv	ille,	own, State, Zip Maryla	code) and 20850
timore	permit. Pages 1 Department of H Important: If Iten any Injury or ott		20a. Method of Disposition  1		Judean	Memor	ial G	dns 1		009	Olney	ion-City or To , Maryl	,
Ba	permit. Departr Importa any inju		21. Signature of Funeral Service License World	newas	A.J	Donat 4400	and Voldres Powde	Bőfgw r Mil	erdt I 1 Roed	Funera d Belt	l Hom svill	e, PA e. Marv	land 20 <b>7</b> 05
1	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the first saying Cause (Disease or injury	a. Metasta  Due to (or as a	the death. Do not e. etic Canca consequence of):		ode of dyin	g, such as	cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a	consequence of):								
.O. Box 6	death certifi e attending I d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death	3 ☐ Ectopi 5 ☐ Other	c pregnancy (specify)	,		75 .	23d.	Date of delive Month	ry Day Year
ords, P.	law requires that the de as been signed by the 2 should be detached	ρ	Part II. Other significant conditions co	ntributing to death but	t not resulting in the	e underlying	cause give	en in Part I.					e cause of death? ably 4 XUnknown
Vital Records,	it The law ricate has be page 2 shu	Completed						_		24a. Was an autops perform	v i	4b. Were autop prior to con death? 1 ☐ Yes	osy findings available opletion of cause of
<u> </u>	ysıcıar is certif directol	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	ıt 2 ☐ ER/Outpa	ient 3 🗆	Othe			heck only on		Other (aData)	ghters Hame
DIVISION OF	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification: To	27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day,		e of	28c. Injury Work		28d.	. Describe ho			givees rule
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:	the host	Medical	one)	sician: To the best of ner: On the basis of and manner state	examination and/o	investigati	on, in my op	oinion, deat	d place, and h occurred a	at the time, da	ate and pla	ce, and due to	the cause(s)
1	8 4 8		29b. Signature and title of certifier	/			9c. License D47			2		ery 13,	
,			30. Name and address of person who co						er Sna	ina M			
	Stat Registra	-	31. Date filed (Month, Day, Year)  JAN 15 2003	32. Registrar				OTIV	or Shr	71189 I	юту та	51IU 2U9	02
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			For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of I rtificate of		ental Hygie Reg.	2009	02617
			Decedent's Name (First, Middle	e, Last)				2. Date of Death	<del></del>	3. Time of Death
	Physici		Robert Eldon Ma	erston			,		Day Year 1. 2009	5:39 P <sup>M</sup>
-	/Medid Examir		4a. Facility Name (If not institution		er)	4b. City, Town, o	or Location of Death		4c. County of Death	<del></del>
			Montgomery Gene	eral Hospit	al	01ne	y		Montgome	rv
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	pplace (State or Foreign intry)
	Director		170-01-0573	1⊠ M 2□ F	90 Yrs.	Working Days	Tiours Willi		1918 Ohi	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		5787211		10d. Inside City Limits
	f sho	ō	Maryland Montgo	omerv	Silver S					1 ☐ Yes 2 ☑ No
	the N	Director	10e. Street and Number		DIE VOI	10f. Zip Code		100	Citizen of What Cou	
	death with the Maryland rns 23a or 28a-f show Livust be rotified at	Ö		omal Dudaya	#700					
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinations to confine an once.	by Funeral	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	No WOLLG	If Yes, specify Cub 1 □ Yes 2 🛛 No	Hispanic Origin? (Spec an, Mexican, Puerto F Specify:	ican, etc.)	Black, White,	
0-	2 hou	Completed	15. Deceden	t's Education	16a. Dece	dent's Usual Occup	pation	16b	o. Kind of Business/Ir	
215	7. nin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4d	life	kind of work done DO NOT use retire	during most of working d)	9		
212	d within giene. er than "	ĕ	Elementary/Secondary (0-12)	5+	Mini	İster			Religion	
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<u> a</u>	uld b Ments arked	2	Clarence Dean N	Marston			Luella S	ands		
Maryland 21215-0036	2 should be finand Mental Fismarked of aumatic ever	ľ	19a. Informant's Name/Relations				and Number or Rural			
	and and a salth n 27 in 27 in er tra		Julia E. Marsto	on (Wife)	3/01	Internat	ional Driv	e, #709,	Silver S <sub>1</sub>	pring, MD
ore	of H of H if iter		20a. Method of Disposition 1 □ Burial 2 🖾 Cremation	2 Demoval from Sta	20b. Place of Dispo cemetery, crei	matory`or other pla	ce) Janua	P37 13	. Location - City or T	own, State
Ë	Pages ' Iment of Itant: If Ite Iury or of		4 □ Donation 5 □ Other (S	pecity)	Metropol Cremato	litan	200 ess of Facility DeV	9 A1	exandria,	Virginia
Baltimore,	permit. Departr Importa any Inju		21. Signature of Funeral Service	Licensee Lu	10	2. Name and Addre	ess of Facility DeV Park Driv	ol Funer e, Gaith	al Home, ersburg, l	MD 20877
			23 Part 1. Enter the disease, or shock, or heart/failur. List	complications that caus	ed the death. In not en	ter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 1	JOCULE	1 Inc	-ester-			Onset and Death
	/Medical		resulting in death)	Due to (or a	as a consequence of):					
	Examiner		Sequentially list conditions,	b 20	Roma	Arhen	y Disc	+50		
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P.0	that the de ned by the detached		Part II. Other significant condition	ons contributing to death	but not resulting in the u	nderlyina cause aiv	en in Part I.	23e. Did tobaco	co use contribute to t	he cause of death?
Records,	w requires that been signed should be det	Completed by	Aloual	Fibrilla	1.0-			1 □ Yes	2. No 3 Pro	bably 4 🗍 Unknown
ec	law las b	ed L						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
=	: The	Sol						performed 1 ☐ Yes 2	death?	
/ita	ysician: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		
of \	hysl this o		1 ☐ Yes 2 No		itient 2 R/Outpatier	0	er: 4 Nursing Hom	e 5 🗆 Residence	e 6 ☐ Other (Speci	fy)
Ē	ing Ph	ü.	27. Manner of Death 1   ↑ Natural 5 □ Pending	9	njury 28b. Time o Day, Year) Injury	Wor	k?	d. Describe how in	njury occurred	
sio	tend leath tor: / the fi	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be			Yes 2 □No			
Division of Vital	or At ifter d Sirect in by	Certification: To	4 ☐ Homicide determ	ined 28e. Place of I building,	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office	28	If. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,
	urs a		29a. Certifier	- Dharlatan Tarina ha			- 1			
	To the Hospital or Attending Phy, within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only one)	Examiner: On the basis and manner	st of my knowledge, deat of examination and/or in stated.	vestigation, in my	me, date and place, all prince,  d at the time, date	e(s) and manner as and place, and due t	o the cause(s)	
	To To T	Σ	29b. Signature and title of certifier	Il mis		29c. Licens			Date signed (Month,	Day, Year)
	10+1			-07,		13C	1082030	1	1 (13 109	
	1 -		30. Name and address of person			*				
			Matthew Connoll			Philip D	rive, Olne	y, MD 208	332	
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 15	2009 32. Degis	etrar's Signature	aked				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 11, 2009 Susan M. Mortfeld /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number 213-66-2247 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth Dec. 22, 1952 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 56 Months Days Hours Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Modical Examinational be mutilised at 10b. County 1 ☐ Yes 2X No Maryland Anne Arundel Lothian Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 20711 United States 794 Marlboro Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 □Yes 2 □No Baltimore, Maryland 21215-0036 Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Louis Mortfeld Mary Lee Iglehart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4748 E. Flanders Lane Harwood, Maryland 20776 M. Hannah Jenkins -sister permit. Pages 1 and:
Department of Health
Important: If Item 27
any injury or other tr.
once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory 1/12/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
MONTHS Immediate Cause (Final disease or condition resulting in death) Stage 3B Ovarian Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Bilateral Malignant Pleural Effusions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Malignant Ascites Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Obstructive Nephropathy - Bilateral DVT; Rt. leg 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 2No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Suparich, Rsu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year JAN 15 2 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Fillmore Murray Mullinix 2009 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 6. Sex 1 M 2 □ F 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 217-28-0878 Director 8, 1922 Maryland Mar. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Madical Examination to the traumatic event, it a Madical Examination to the condition once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐Yes 2 No Maryland Frederick Mount Airy 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5321 Dove Drive <u>21771</u> USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII \$ 1 ☐Yes 2 📉 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) custodian Public Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, Millard Fillmore Mullinix Ethel Day 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5321 Dove Drive, Mount Airy, Maryland Eleanor Anne Mullinix, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/15/2009 Alexandria, Virginia 21. Signature of Funeral Service Liones e 22. Name and Address of Facilit Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ancreatic etastatic Weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) Day Year 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an autopsy performe certificate 1∐Yes 2∭ No After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: Aft

filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D43091 1-14-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+ House Aue Zuid! MO 801 TOLL 50

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

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	For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>		Mental Hyg ғ	giene Reg. No. O. O. O.	00000
ın	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day Year	1.4
al -	Margaret Grace Ma						11, 2009	2:01 P <sup>M</sup>
er		ve street and number)  Sex 1□ M 2፟ T F 86	ast birthday) Yrs.	4b. City, Town, or  Ijamsvil  If Under 1 Year  Months Days		8. Date of Birtl	Frederic h, Year) 9. Bi	k rthplace (State or Foreign
_	Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	ocation				10d. Inside City Limits
ctol	Maryland Frederic	k Ijam	sville					1 □Yes 2 X No
al Dire	10e. Street and Number 2548 Urbana Pike			10f. Zip Code 21754			10g. Citizen of What C USA	ountry?
Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 🕅 Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S In, Mexican, Puer Specify:	pecify Yes or No-	14. Race - Am Black, Wh	
sted b	15. Decedent's E	Education		dent's Usual Occup		rkina ı	16b. Kind of Busines	
mple	Elementary/Secondary (0-12)	College (1-4or 5+)	homem	DO NOT use retired	)	, and	own home	
Be Co	17. Father's Name (First, Middle, Las	t)	nomen	lakei	18. Mother's Nar	me (First, Middle,	Maiden Surname)	
To B	Walter Brooke Sha	1W			Caroline	e Cather:	ine Cannab	augh
	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street a	and Number or Ro	ural Route Numbe	er, City or Town, State,	Zip Code)
	Patricia Barrick,			Urbana Pi	ke, Fred	derick,	Maryland 20c. Location - City of	21754
	1 ☐ Burial 2 📉 Cremation 3 [	☐Removal from State	emetery, crei	matory or other plac	i i		,	
	4 □ Donation 5 □ Other (Special Signature of Juneral Service Lice		22	2. Name and Addres	ss of Facility Mo	leswort	Alexandria n-Williams Maryland	Funeral Home 20872
	23a. Part1. 7. e the disease, or con shock, or h art failure. List only Immediate cause (Final disease or condition	y one caus a orl each line.	n. Do not ent	-	g, such as cardia	c or respiratory ar		Approximate Interval Between Onset and Death
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence)  Due to (or as a consequence of the co	· ·					
Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of do Month	elivery Day Year
d by Pi	Part II. Other significant conditions	contributing to death but not resu	_				bacco use contribute ′es 2□ No 3□ F	to the cause of death? Probably 4 Junknown
Somplete	VISEA8E					24a. Was a autop perfor	an 24b. Were a prior to death? 2 No 1 □ Ye	
Be (	25. Was case referred to medical examiner?	Hoositali		l ou		ath <i>(Check only or</i>	ne)	
P	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time o Injury	Work	4 □ Nursing F		ence 6 □Other (Sp ow injury occurred	ecify)
Medical Certification:	2	De 200 Blace of injury. At ho	me, farm, str		763 2 110	28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
edical C		hysician: To the best of my know miner: On the basis of examinat and manner stated.						
Me	29b. Signature and title of certifier	son no		29c. License	number 1936		29d. Date signed <i>(Mor</i>	
te	30. Name and address of person who A DONELSO.  31. Date filed (Month, Day Year)	V MD 650	2 77	som As	JOHNS	N de.,	FREDERIG	CK, 21702
ar 01	31. Date filed (Month, Day Year)	pann p.	FIRM					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Harvey Weldon Mariner, Jr. 2009 Z:50 AM 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastal Hospice Salisbur at WICOMICO 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Min 215-07-3632 91 Director 11-04-1917 Mary Land Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No DE Sussex Seaford 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 29118 Ellis Mill Road 19973 USA Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after-Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. \$ 3 Widowed 4 Divorced Specify: "natural", White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Dupont Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey W. Mariner, Sr. Julia Huffington ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Nadine Cavey/daughter 1020 Tyler Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 128 Burial 2 Cremation 3 Removal from State Allen U.M. Cemetery 01/21/2009 4 ☐ Donation 5 ☐ Other (Specify) Allen, Maryland 27. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2/ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICIZ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 72 ☐ Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) Within 2 29b. Signature and fittle of certifier 29c. License number

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASTAZ

32. Redistrar's Signature

CHUGAM WARY

**JAN 21** 

31. Date filed (Month, Day, Year)

20058410

HOSPICE POBOX 1773

29d. Date signed (Month, Day, Year)

			For State Registrar		State of	Maryiai		e <i>rtificate</i> d			-	gierie Reg. No. <i>1</i>	2009	02622
	D		1. Decedent's Name	e (First, Middle, I	_ast)						2. Date of De Month		Year	3. Time of Death
	Physici: /Medic		Hartley	Vincent	Martin						Januar	y 19,	2009 ear	2:30 A M
	Examin		4a. Facility Name (/	_		ber)		4b. City, Tow					ounty of Death	
-/			Wilson He			7. Age (In yrs	last hirthda	Gaithe		er 24 Hrs.	8. Date of Bir		tgomery	place (State or Foreign
ı	Funeral Director		5. Social Security N  107-32-20  Usual Residence of	038	Sex 1X∏ M 2□ F		90 Yrs.	Months Da			8. Date of Bir (Month, Da Oct 19	, 191	Couit	York
	land low		10a. State	10b. County	····	10c. C	ity, Town or L	ocation					1	0d. Inside City Limits
	Mary a-f sh	tor	MD	Montgom	erv	Gai	thers	burg						1 □Yes 2 □ No
	or 28	Director	10e. Street and Nur					10f. Zip Co	de			10g. Citize	n of What Cour	ntry?
	23a		407 Russe	ell Aven	ue #511			20877				USA		
	er dez	Funeral	11. Marital Status	35	12. Was Deced	ces?	J.S. 13	. Was Decedent If Yes, specify (	of Hispanic Cuban, Mexic	Origin? (Spo can, Puerto	ecify Yes or No Rican, etc.)	- 14.	. Race - Americ Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modical Eventine Least be incitived at	by F	1 ☐ Never Marri 3 ☐ Widowed	ied 2€ Married	If Von Cive	2    NO e tes: 1944	4-45	1 □ Yes 2 <b>X</b>	No Speci	ify:		S	pecify: Whi	te
21215-0036	atura cal E			15. Decedent's	Education	.oo. 17-4-	16a. Dec	edent's Usual O	cupation			16b. Kind	of Business/Inc	
212	hin 7.	Completed	(Spec	cify only highest gondary (0-12)	grade completed)  College (1-	4or 5+)	(Giv life.	e kind of work de DO NOT use re	one during m tired)	ost of work	ing			
2	ed wil	S	•		5+		Teac	her					ation	
gug	ould be file Mental H arked oth atic even	Be	17. Father's Name								e (First, Middle, Eloise			
ž	2 should and Mer is marke raumatic	ဥ	Royal Bly				10h Mai	ling Address (St	1					Code)
Z	and 2 s ealth ar n 27 is ner trau		Jane C. N					Russell						
Jre,	of Hei	18	20a. Method of Disp			20b.	Place of Disp	osition (Name o	f place)		Date	20c. Loca	tion - City or To	own, State
Ë	Pages ment of lant: If ite		1 □ Burial 2) 4 □ Donation	Cremation 3 5 ☐ Other (Spe	☐ Removal from S cify)	iaie i	Arund	el Crema	atory				on, MD	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In. M. dical Eventine 1, and be in titling at once.		21. Signature of Fu	uneral/service Lic	te ette	MO:	L251	Going Ho Beverly	ome Cr L. He	ematic ckroti	on Serv	ice l	P.O. Bo rksvill	x 784 e, MD 21029
			23a. Part 1. Enter the shock, or hea	he disease, or co	mplications that ca ly one cause on ea	used the dea								Approximate Interval Between
and .	Physician	ì	Immediate Cause ( disease or condition		Cas	ma	ry	arte	24	isi	ase			Onset and Death
	/Medical Examiner		resulting in death)		Due to (c	or as a consec	quen of):		1					
		Į.	Sequentially list con if any, leading to im	nditions,	b. — Due to (c	r as a consec	quence of):							
	uted d ansit	Examiner	Cause (Disease or	eriying injury										
oʻ	ificate be executed g physician and as the burial-transit		that initiated events resulting in death) I	Last	Due to (c	r as a consec	quence of):							
68760,	ate be hysicii he bu	edical			d									
	- 0, @	Med	IF FEMALE:											
Вох	leath certific attending p	ian	23b. Was decedent in the past 12			ome of pregn rth 2□ Feta ant at time of	al death 3	☐ Ectopic pregr				230	d. Date of delive Month	ery Day Year
o	at the de by the tached	Physician/M	1 □ Yes 2 □ 9 □ Unknown		9 Unkno		death 5	Other (specif						
ď.	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death, within 24 hours after death. To the Funeral Director; After this certificate has been signed by the attending the time of the Funeral director, page 2 should be detached for use completely filled in by the funeral director, page 2 should be detached for use.		Part II. Other signif	ficant conditions					given in Par	rt I.	23e. Did to	obacco use	contribute to the	ne cause of death?
Vital Records,	iw requires that s been signed t should be deti	Completed by	- Treat	ejevi	caus	ridia	wee	2 11.00	com	LAKU.	101	/es 2 🖫 1	No 3□ Prob	pably 4 ☐ Unknown
ecc	elawre hasbe ge 2 sho	plet	conges	iliveh	early	ulu	se. r	yperl	ens	in	24a. Was autop	sv .	24b. Were auto	psy findings available mpletion of cause of
= E	: The cate h	Con	Dem	entie	. Osten	nrth	rete	c. 4300	tem	is	perfo 1 □ Yes	rmed?/	death? 1 ☐ Yes	·
Vita	sician: Th certificate rector, pag	Be	25. Was case reference examiner?		Hospital:				Othor	/	n (Check only o			
<u>o</u>	Phys ral dir	<u>۲.</u>	1 ☐ Yes 2 ☐ 27. Manyer of Deatl		Hospital: 1 ☐ In		ER/Outpati 28b. Time	ent 3 DOA	4년		me 5 Residence Residence Residence 1		Other (Specif	(y)
on	ding F h. After funer	tion	1 Atural	5 Pending investigati	(Month	n, Day, Year)	Injury		Injury at Work? 1 ∐Yes 2		zou. Describe i	iow injury o	Curred	
Division	or Atten after deatl Director; in by the	ifica	2 Accident 3 Suicide	6 Could not	be 28e. Place of	of Injury - At h	ome, farm, s	treet, factory, off					Number or Rura	il Route Number,
á	pital or A	Certification:	4 ☐ Homicide	/	bullain	g, etc. (Speci	uy)				City or Tov	vn, State)		
	lospit t hour unera		29a. Certifier (Check only		Physician: To the baminer: On the ba									
	To the Hospitai within 24 hours a To the Funerai I completely filled	Medical	one) 29b. Signature and		and manne				ense numbe				signed (Month,	
	5 <u>5</u> ≦ 5			spects		/	(/.	1 0	74/1	5	-	Lam	iarn	19.2009
	(K)		30. Name and addr	1177		of death (Ite	m 23a) (Type	Print 20	DU	(58/	LAW2	AIL	8	1)01
(	4/2		14. RO.	BERT	DIKSCH	1314	(1)	64	THE		ina, n		20877	,
	Sta		31. Date filed (Mon.	th, Day, Year)	2009 32. 8	gistrar's Sign	ature	1						
	Registr	ar		UNIT & U	2003	neva	12. 14	Barker						

09-0044	4
Michael	Maddox

44 I Maddox	1	State of Maryland / Department of Health and Ment  -For State  Certificate of Death	tal Hygiene	2009 0262
Physicia al Examir	ın/	1. Decedent's Name (First, Middle,Last)  Michael Anthony Maddox	2. Date of Death Month I January 15,	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Bladensburg  4b. City, Town, or Location of Bladensburg		4c. County of Death Prince George's  (MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		085-56-4764 1XM 2F 48 Yrs. Months Days Hours	er 24Hrs. 8. Date of Birth 05/18/	Farrian
nd how any		Usual Residence of Decedent   10a. State		10d. Inside City Limits 1 X Yes 2 No
2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once,	Directo	10e Street and Number 5005 Townsend Way Apt B3 20710		g. Citizen of What Country? USA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No  13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	ı, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
2 hours after "natural", I Examiner	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  1 Yes 2X No specify:  16a. Decedent's Usual Occupation (Give during most of working life. DO NOT	kind of work done	16b. Kind of Business/Industry
ed within 7. Iygiene. other than he Medical	Completed	1-4 Caterer  17. Father's Name (First, Middle, Last)  18. Mother	r's Name (First, Middle, M	
should be file nd Mental H is marked atic event, t	To Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Nur  Rence Maddox-wife 5005 Townson Wa	mber or Rural Route Number y #A4 Blade	ber, City or Town, State, Zip Code) nsburg MD 20710
ges 1 and 2 s of Health a If item 27 ther traum		20a. Method of Disposition  1 Rurial 2 X Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State Alexandria, VA
permit. Pag Department Important: injury or o		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  Metropolitan  22. Name and Address of Facility  Marshall's Fun	ty 42	1/ 9th St. NW ashington DC 20011
xaminer	aminer	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Loss of hypertensive at Omplications of hypertensive at Object (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
be executed ician and urial - transit	ical	d. X UNPENDED X AMENDED 23a,27,perME, g888 2/4/09 10e, 17,18 & 19b,per Inf G	TT 8891 5/12/09	TT
death certificate be the attending physicial for use as the burial	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	pic pregnancy	23d. Date of delivery  Month Day Year
ng Physician: The law requires that the d After this certificate has been signed by the meral director, page 2 should be detached	وُ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	1 Yes	obacco use contribute to the cause of death?  S 2 No 3 Probably 4 V Unknow
he law requir ate has been s age 2 should	Completed		24a. Was autop perfor 1 ✓ Yes	prior to completion of cause med? death?
tending Physicians. The law requires that the death certificate be earth.  or: After this certificate has been signed by the attending physici the funcral director, page 2 should be detached for use as the buri	To Be	25. Was case referred to medical examiner?  1 V Yes 2 No  128a Date of Injury  28b. Time of Injury  28c. Injury at Wo		Residence 6 Other: Scene how injury occurred
fter d Jirect in by	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, (Specify)	or Town, S	
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	1 293 Lentiles	occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
)	M	Calmy f O.C.M.E.	ei	January 16, 2009
		30. Name and address of person who completed cause of death (tem 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201	

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Olaio oi iii	y	Cert	ificate of	Death		Reg. N.2 0 (	9	026	24
	Physicia	_	1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	26, 2009	Year	3. Time of I	
	/Medica	_	Hazel Mass	3er					January			9:02	AM
	Examine	r	4a Facility Name (If not institution, give					4b. City, Town, or I		4c. County			
			Northampton Manor He				Kille des 4 Venn	Frederic			Frede		
3	Funeral Director		214-10-1070	Sex 7. Ag I□M 25√F	e (In yrs. la 96	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat 12/04/	y, Year) 1912	9. Birthpl Count Mary	ace (State or ry) Land	Foreign
	pu	- 1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	, Town or Loca	ation				10	d. Inside Cit	y Limits
	Manyle f sho	5	Maryland Freder	ri als	Frod	derick						1 ☐ Yes	2 🗆 No
	28e	၌  -	Maryland Freder	ICK	rrec	GELTCK	10f. Zip Code			10g. Citizen of W	/hat Count	try?	
	The second	5	489 Carrollton	Drive			217	01		United	d Sta	tes	
	Jeath 2	era	11. Manital Status	12. Was Decedent	Ever in U,S	3.   13. W		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	14. Race	- America		
21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hyglena. Important: if item 27 is marked other than "natural", or itema 23a or 23a-f show any injury or other traumatic event, tra Medical Examinat must be notified at another.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give △ Year or Dates:	No	1	Yes, specify Cub ☐ Yes 2  No		o Hican, etc.)	Specify:	k, White, e Whi		
2-0	72 ho	3	15. Decedent's E (Specify only highest gr	ducetion		16a. Decede	nt's Usual Occup	ation during most of wor	kina	16b. Kind of Bu	siness/Ind	ustry	
21	E B B	ğ.	Elementary/Secondary (0-12)	College (1-4or 5	5+)			during most of wor d)			C		
2	Ygier f	် ပ	10			OWI	ner/oper	ator 18. Mother's Nar	na (First Middle	motel d		taurar	nt
n a	tal H de de de de de de de de de de de de de	m l	17. Father's Name (First, Middle, Last Chester Wolfe	)					e Anne R			lharas	2r
₹ Z	2 should be filed with and Mental Hygiena. Is merked other than aumatic event, tree!	2				401 14 111	A.1.1 (0)	l					- L
	and rand		19a. Informant's Name/Relationship	•				and Number or Ru rook Dr.					
	s 1 end of Health Item 27 other tr	-	Melvin Heim / bro	tner	20h Pla	ace of Disposi	ition (Name of		Date	20c. Location -			
	permit. Pages Department of I Important: if Ite any injury or of		1 Burial 2 □ Cremation 3 E 4 □ Donation 5 □ Other (Speci		CO	Olive	t Cemete	ry	1/30/09	Freder	ick,	MD	
Balt	permit. Departinimporta		21. Signature of Funeral Service Lice		01222			ess of Facility Ke nurch St.	~				ne
9	Physician /Medical Examiner	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ab.	Due to (or	as a consequ	ence of):						
Box 68760,	- 00	by Physician/Medical E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or	as a consequ	ence of):						
0	the a	ysic	Part II. Other significant conditions		ut not resul	iting in the und	derlying cause gi	ven in Part I.		tobacco use cor			
P.0	thet the	<u> </u>	Ostoa	Autis					1 🗆	Yes 2 No	3∐ Prot	pably 4 □ I	Unknown
Records,	ow requires thet the deeth cers is been signed by the attending should be detached for use	Completed b							24a. Was perfo	an autopsy rmed?	ava	ere autopsy fi ailable prior to mpletion of ca death?	)
Œ	The le	E							10	res 20 No	10	Yes 21	No
ita	mrifica tor, p	Be	25. Was cese referred to medical					26. Place of De	ath (Check only o	one)	1		
of Vital	Physician: this certific ral director,	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatio	ent 2 E	ER/Outpatient	3□ DOA OI	her: 4 Nursing H	lome 5□ Resi	dence 6 Othe	er (Specif)	1)	
	To the Hospital or Attending Physician: The lew within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	28b. Time of Injury	28c. Inju Wd M 1	ryat irk? ]Yes 2 ☐ No	28d. Describe	now injury occurr	red		
	is aftar de in Directo ed in by ti	edical Certification:	3 ☐ Suicide 6 ☐ Could not determined	280. Place of in	ury - At hor c. (Specify,	me, farm, stre	et, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	i Route Num	ber,
	To the Hospital or within 24 hours aft.  To the Funeral Discompletely filled in		29a. Certifier 1 CertifyIng P (Check only one) 1 Medical Exa	hysician: To the best minar: On the basis o and manner st	f examinati	vtedge, death ion and/or inve	estigation, in my	opinion, death occu	e, and due to the urred at the time,	date and place,	and due to	the cause(s	)
	Vithi To the	Σ	29b. Signature and title of certifier	Lague M	D.			se number 0546	36	29d. Date signed	d (Month, 26/	200	9
_	V		30. Name and address of person who Syed W, +	laque	700	) Mo1	haire 63	re Ave		edenie	KI	d.21	701
	Stat Registra		31. Date filed (Month, Day, Year)  FFR 0 2 2009	32 Registr	ar's Signat	ture the	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JOHN WILLIAM NICHOLLS 2:30 P M Jan. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Madonna Heritage Jarrettsville Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral ™** M 2□ F 067-18-2801 86 4/14/1922 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or items 23a or 28a-f showdow Examiner must be notified at 1 ☐ Yes 2 No Director MD. Harford Monkton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3604 My Ladys View Court Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filled within 72 hours after of Health and Mental Hygiene. 1 XNever Married 2 ☐ Married 1 Yes 2 If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 WW II Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the unknown Maintenance Manager Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Nicholls Ethel ၉ Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maud E. Ziegler (Niece) 3604 My Ladys View Court Monkton, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any Injury or ot once, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highyiew Mem. Gar. 1/28/2009 Fallston, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Mucklar Home, P.A. Jarrettsville, Maryland 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each ne. Immediate Cause (Final **Physician** Que to (or as a consequence of): doys disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a sequentially in the case of the c Due to (or as a consequence of): Examine the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ASCUD certificate has tirector, page 2 s autopsy performed INTN 2 **□** No To the Hospital or Attending Physician: director. 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1955 444 Liu 1 | Yes 2 | → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Atural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 3/298 MO 1/27/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wend 1 Closs Z 31. Date filed Month, Day, Year) MO 5701 pro ve Rout

Registrar

State

DHMH 17 Rev 1/2001

32. Registrar's Signature

**ORIGINAL** 

			For State Registrar	State of	Marylan	•	rtment of tificate o			ental Hy	gien Rea. N	2009	0	2626
	BI		Decedent's Name (First, Middle, L	ast)				<del></del>		2. Date of De	eath			ime of Death
	Physicia /Medic		Rhoda Peregof	f Os	trow					Januar	y 12	2, 2009	3	:30pm <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, g		ber)		4b. City, Town,		of Death			c. County of Dea		
of i			5002 Danbury Cour 5. Social Security Number 6.		. Age (In yrs.	last hirthday)	Bethes If Under 1 Year		er 24 Hrs.	8 Date of Bi	,	Iontgome		State or Foreign
	Funeral Director			1 □ M 2 🛣 F	79	Yrs.	Months Day		Min	8. Date of Bi (Month, D )9/19/	ay, Year 1929	Mar	ylar	
-	pu ,		Usual Residence of Decedent		1.0									
	shov	'n.	10a. State 10b. County			y, Town or Lo								ide City Limits ☐Yes 2 ☐ No
	28a-f	rect	Maryland Montgo	mery	Ве	thesda	10f. Zip Code				10g. C	itizen of What Co		X
	3a or	al Di	5002 Danbury Cou	rt			208	14				ted Stat	-	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evan from the coolified at	Funeral Directo	11. Marital Status	12. Was Decede		S. 13. V	Vas Decedent of Yes, specify Ci	f Hispanic C	origin? (Spe	cify Yes or N	0-	14. Race - Ame Black, Whit	erican Ind	ian,
20	or it	by Fu	1 Never Married 2 Married	1 □Yes 2 If Yes, Give	⊠ No		l□Yes 2 <b>X</b> IN			, , , , , ,		Specify: Wh		
215-0036	thin 72 hours after death with the Marylan e. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at		3 ☐ Widowed 4 ▼ Divorced  15. Decedent's	Year or Date	es:	16a. Deced	tent's Usual Occ	cupation			16b. I	Kind of Business		
2 <u>1</u> 2	s filed within 72 h If Hygiene. other than "nati rent, II. Medic	Completed	(Specify only highest g	rade completed) College (1-4	lor 5+)	(Give	kind of work dor DO NOT use reti	ne during mo	st of workir	ng			,	
		Com	Ziomoniary/0000naary (0 12)	2		Artis	t				Ar			
ng L	be file	Be	17. Father's Name (First, Middle, Las	it)						(First, Middle		n Surname)		
Maryland	hould d Mer marke matic	은	Ellis Peregoff  19a. Informant's Name/Relationship	(Time Print)		10h Mailin	Addroon (Stra			Savet		or Town, State,	Zin Codo	
Z Z	id 2 sl lith an 27 is r r traur		Lee Ostrow	son								Spring,		
ē,	s 1 ar of Hea item		20a. Method of Disposition			Place of Dispo	sition (Name of	i	Jan 1			Location - City or		
Ē	Page nent c		1 ☐ Burial 2 🏖 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ematorv	etery or other p	, r.    -  -	2009	,	Ale	xandria,	, VA	
Baitimore,	permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygler Important: If item 27 is marked other th any Injury or other traumatic event, III.		21. Signature of Funeral Service Lic	ensee		22	. Name and Add							
L	20 E 29	1 1	Curtis C	Lay			E Deer					rg, MD.	208	
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	ly one cause de eac	ch line.			lying, such a	as cardiac o	r respiratory	arrest,		Onse	oximate val Between t and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		Cance	r						8 m	onths
	Examiner			Due to (o	r as a conseq	uence of):								
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United as a tripling	b Due to (o	r as a conseq	uence of):								
	ecuter ind transi	Examiner	triat irritiated events	c										
Š,	icate be executed physician and s the burial-transit	a E	resulting in death) Last	Due to (o	r as a conseq	uence of):								
58760,		edica		d										
XON	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		7					23d. Date of de	livery	
	ed for	sicia	in the past 12 months? 1 □Yes 2 ☒No		rth 2 □ Feta ant at time of o		Dectopic pregnation of the control o					Month	Day	Year
7. O	uires that the de signed by the a d be detached fo	Phy	9 Unknown			udaine in about		ahaan la Daw		220 Did	tobasas	use contribute t	o the nav	ne of dooth?
ďŠ,	ires the signer	þ	Part II. Other significant conditions	contributing to dea	atn but not res	uiting in the ui	nderlying cause	given in Par	τι.			o use contribute t		
ecords,	requer peer shoul	Completed								24a. Wa				
ě	e la e la e 2	duc								auto	opsy formed?	prior to death?	completion	dings available on of cause of
Vital	slcian: Th certificate rector, pag	Be Co	25. Was case referred to medical					26. Pla	ce of Death	1 ☐ Yes (Check only		ło 1 □Ye	s 2 🗆 N	lo
	ys dir	To B	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ In	patient 2	] ER/Outpatier	nt 3 🗆 DOA			<u> </u>		6 ☐Other (Spe	ecify)	
n o	<b>5</b> 0 0		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of (Month	f Injury ı, <i>Day, Year)</i>	28b. Time of Injury	f 28c, fr	njury at Vork?	2	28d. Describe	how inj	ury occurred		
<u> </u>	Attending it death. ector: After by the funer	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	he	flaire. As to			□Yes 2[	-	201 1	(0)			
DIVISION	after a Direc	Certification:	4 ☐ Homicide determine	d 28e. Place o	g, etc. <i>(Speci</i>	fy)	eet, factory, offic	e	4	City or To	(Street a	and Number or F ite)	urai Hout	e Number,
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun			Physician: To the b										
	he Ho in 24 i he Fu pletel	Medical	(Check only 2☐ Medical Ex	aminer: On the bas and manne	sis of examina er stated.	ation and/or in	vestigation, in m	ny opinion, d	leath occurr	ed at the time	e, date a	nd place, and du	e to the c	ause(s)
	Vith Com	Σ	29b. Signature and title of certifier	1				ense numbe	r		29d. D	Date signed (Mon	1	
	9		Butch					014			1/13	NUMY	15/4	2009
			30. Name and address of person what Isabella C. Mart	·	,		*	Laur	al Mi	n 20	707		*	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Re	gistrar's Signa	ature		шаці	CII CII	20	, 0 /			
	Regist		JAN 15 2	2009 Z	we,	6. Sa	Med							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 13,2009 O'NEILL BEVERLY MAY 4:30 A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 6366 Albers Mount Airy If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) OCT.24, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Director 92 Pennsylvania 219-01-4892 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Extended must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 6366 Albers Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Rlack. White, etc. 1 ∐Yes 2 🟋 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 2 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Developer Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harman Albers Kirchin May ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry O'Neill / Son 4001 Windsong Way / Mount Airy, MD Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ■ Burial 2 □ Cremation 3 □ Removal from State 1-16-2009 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery Mount Airy, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 8 E. Ridgeville Blvd./ Mount Airy, MD 21771 Luc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wecks CV disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): physician a the burial-P.O. Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 Tes 3 Probably 4 Unknown plnous Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy perform certificate 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2☑No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100059943 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onn (-Asselvo 295 He 307 SPYRY 31. Date filed (Month, Day, 32. Régistrar's Signature

DHMH 17 Rev 1/2001

Registrar

16

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			For		State c	of Ma	ryland	d / De	par	tmen	t of H	lealth	and N	/lental H	ygien	e 🔾	00	
			- State Registrar					C	ert	ificat	e of L	Death			Reg. No	. Z	009	9 0262
	Dhuaiai		1. Decedent's Name	e (First, Middle, La	ast)									2. Date of D	eath Da		Voor	3. Time of Death
	Physicia /Medic		Mildre	d Rebecc	a Parsl	ey								Janua	ary 2		2009	12:12 P <sup>M</sup>
	Examin		4a. Facility Name (/			4	4b. City,	Town, or	Location	of Death								
25		Ravenwood Lutheran Village							Hagerstown					Washingto				n
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs							~,,,	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E	irth Day Year	)	9. Birth	place (State or Foreign
	Director		218-30-	9059	1 ⊔ м 21 💥 F		90	Yrs	S.	Nontrio	Duyo	riodio	Willin.	April				yĺand
	P P		Usual Residence of 10a. State	Decedent 10b. County			10c. City	Tarres		Ain -								10d Inside City Line
	the Marylan r 28a-f show	'n																10d. Inside City Limits 1 X Yes 2 □ No
	8a-f	Director	MD	Washing	ton		Hag	erst	OWI	_								
	or 2	Dir	10e. Street and Nur							10f. Zip					10g. C	tizen of	What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show r must be nutified at	<u>a</u>	1183 Lu	83 Luther Drive						2.	1740			USA				
		Funeral	11. Marital Status	er in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto					ecify Yes or N	10-		ace - Ameri ack, White,	can Indian,					
2	hours after tural", or Ite	by Fi	_	Armed Forces?  or Married 2 Married 1 Yes 2 No If Yes, Give					1 ☐ Yes 2 ☑ No Specify:					,		Speci		
2-0036	72 hours 'natural'', dical Exz		3 LX Widowed	4 ☐ Divorced Year or Dates:					TETOS ZENTO OPCONY.								VVII	ite
ဂ်	nati	Completed	(Spec	15. Decedent's E cify only highest gr	ducation ade co <i>mpleted)</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					at of work	working 16b. Kind of Business/In				idustry
7	/ithin han han	g.	Elementary/Seco		College (	1-4or 5+									_	_		-
7	be filed wif tal Hygien d other th event, the		12 t					Admi	nis	stra	tive	Cler		(=1				lector
		Be	17. Father's Name											e (First, Midd		n Surna	me)	
3	should be nd Menta marked matic er	မှ	Andrew J					,						e Hard				
a	d 2 should to the and Meni		19a. informant's Na											al Route Nun				
2	- R N L		Gail R.		/ Daugl	nter	_						ld Me	rcersb	urg,	PA	1732	6-9735
	ges 1 a it of Hea if item or othe			t0a. Method of Disposition 20b.  1 XBurial 2 □ Cremation 3 □ Removal from State						ion (Nan tory or o	ne of ther plac	e) :		Date	20c. l	ocation	- City or T	own, State
Ĕ,	Pag nent ant: 1 ury o			5 ☐ Other (Speci	Ceda							MD						
1 XBurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee					nsee /	7		. ICINVI		morail Cardens 1/26/09 Hagerstown, MD Name and Address of Facility Gerald N. Minnich Funeral Home						neral Home		
מ	89 = 88	21. Signature of Fundial Service Liberisee						305 N. Potomac St. Hagerstown, MD										

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

**Physician** /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Be Completed by Physician/Medical

Immediate Cause (Final

disease or condition resulting in death)

acute myocardial Parction Due to (or as a consequence of): Hypertensive Due to (or as a consequence of): Due to (or as a consequence of):

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

02628

Approximate Interval Between Onset and Death

modiate

years

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes	2 💆 N
27. Manner of	
1 Natur	
2 Accid	ent

29a, Certifier

Certification: To

Medical

5 Pending investigation 6 Could not be determined 3 Suicide 4 ☐ Homicide

25. Was case referred to medical

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D47451

29d. Date signed (Month, Day, Year) January 22, 2009

canthia Kuther Sand no

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Cynthia Kuttner Sands, no 14214 Paradise Church Road, Hagerstown, Maryland

31. Date filed (Month, Day, Year)

32. Registrar's Signature

BH-8 State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JAN 2 2 2009



09-00475 William H Poole, III

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 02629

Division			or State				C		ate of i	Jean					Reg. No			7.1
		Regi	istrar ecedent's Name	e (First, Mido	le,Last)									Date of D Month	Day	Year		. Time of Death
Physicia al Examir			Willian		nry	Pool	le, III	[						January	16, 20	09		1341 hrs
		4a.	Facility Name (i						41	. City, Tov		cation of	Death			c. County o Anne Art		
			Solomons is	sland Roa	ad & G	rays Road				Lothian								place (State or
Funeral		5. S	Social Security N	Number	6. Sex		7. Age (in yr:	s. last bir	thday)	If Under Months	_	If Under Hours	24Hrs. Min.					
Director			577-58-	8160	1 X	M 2 F		65	Yrs.	Monus	Days	110013		10/0	)5/19	43	Cour	Washington,
			ual Residence o															10d. Inside City Limits
any		10a	a. State	10b. County			10c. C		or Location									1 X Yes 2 No
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Clen Henry Robertson 14, 2009 9:30 P M January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's County If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months 1 M 2 □ F 7. 1922 Sept. Virginia 721-01-9863 86 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No MD Calvert County Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3030 Whispering Drive 1. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Agreed Forces? 1 Plyes 2 No If Yes, Give 20678 U.S.A. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🏋 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Delivery & Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Robertson Mammie Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Whispering Drive Prince Frederick, MD 20678 of Disposition (Name of Date 20c. Location - City or Town, State Gary Robertson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 23 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 4 □ Donation 5 □ Other (Specify) Cheltenham. Maryland 21. Signature of Furteral 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 3125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal disease or condition resulting in death) Due to (or as a consequence on nd Stage Due to (or as a consequence of) arkinson's Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify)

**Physician** /Medical Examiner

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physician

The law requires that the death certificate be executed

Attending Physician:

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Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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'natural", or

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical E once.

filed within 72 hours after death

3altimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

9 ☐ Unknown

1 Yes 2 No

Physician/Medical Part II. Other significant condition ş Completed 25. Was case referred to medical Be 27. Manner of Death Certification:

Medical

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1	s contributing to death but not resulting in the underlying cause given in Part

23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ? No

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		24a. Was an autopsy performed 1 Yes 2 ▼
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on	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes		28d.	Describe how injury occurred
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1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day Year)	Injury M	work? 1 ☐ Yes 2 ☐ No	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At hor building, etc. (Specify	ne, farm, street, factor	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)					ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

(Check only one)	2 ☐ Medical Examiner: On the basis of examination a and manner stated.		
29b. Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCA	BRUNEY	mp	29449	charlotte	HAII	RD	Charlotte HAll MD	20622
31. Date filed (Month, L			Registrads Signatur					

2RW 10+1 State Registrar

32. Registrads Signature 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14 2009  $A^{M}$ 5:35 January Joan Kinsey Reid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕅 F 10-16-1925 83 Indiána Director 294-22-7808 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show items 23a or 28a-f shov 1 Ves 2 □ No Director Bartholomew Columbus IN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 47201 USA 2712 Lafayette Avenue Completed by Funeral within 72 hours after death is 1 and 2 should be filed within 72 hours and if health and Mental Hygiene.
If Health and Mental Hygiene.
Item 27 is marked other than "natural" or items: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 💢 No Specify Specify: white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Bracken McMillen Alfred Charles Kinsey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 630 Sycamore Lane, Owings, MD 20736 Susan K. Reid, daughter permit. Pages 1 a
Department of Her
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 01-15-09 | Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exam sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2□No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ER/Outpatient 3 DOA Certification: To this hours after death. neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29d. Date şigned (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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State Registrar 31. Date filed (Month, Day, Year) 32. Regi

30. Name and address of pure n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

B. Sparks

State of Maryland / Department of Health and Mental Hygiene giene <sub>Reg. No.</sub> 2009 For State Registrar 02632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 **Physician** 2009 Carmen E. Reardon January 8:50 Рм /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mt. Airy Lorien Nursing Home Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 T F Yrs 87 03-22-1921 NY Director 092 14 8722 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ŽĪNo Director MI Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 8302 Sunrise Court United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. 3 Nidowed 4 ☐ Divorced Spanish White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic es Anthony Montanez Edna Murphy ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8302 Sunrise Court Ellicott City, MD 21043 Gerard T. Reardon/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1-15-2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licenses M01044 0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MERS **Physician** MONTHS - YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 to No 3 Probably 4 Unknown 1 □ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performe certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient P this within 24 hours after deam.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1) 26499 January 15. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Drive, Mt. Airy, MD 21771 Dr. Ronald E. Miller 31. Date filed (Month, Day, Year) 32 egistrar's Signature State JAN 16 parket a recent Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:25 P.M. June Beatrice SHANK gnuary 20 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Funeral Months Days Hours 1 □ M 2 🔀 F Director 79 1929 1 219**-**44**-**4097 June Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1X Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 2 Funeral 21740 200 East Wilson Blvd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, Item Medical Exymi Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 21 No Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henry William Harris Lelia Beatrice Whistner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Jennifer Friedrich - Daughter</u> 12462 Randy Drive, Greencastle, Pa. 17225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 1/22/09 Hagerstown, Maryland 21. Signature of Femoral Service Lice 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** anu /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 ANo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Thipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 DNatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D27898 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar FRADUSCO

Year)

31. Date filed (Month, Day,

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Registrar's Signature

MILL ST. HAGERSTOND MD217KO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 02634 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, 2009 Physician Caroline C. Simms 12:20PM anuan /Medical 4a. Facility Name (If not institution, give street and number)
Doctors Community Hospital 4b. City, Town, or Location of Death Lanham 4c. County of Death  $P \cdot G$  . Examiner 7. Age (In yrs. last birthday) 5. Social Security Number 225-60-2705 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth June3, 1945 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 KF Hours Min. Vírginia **Director** Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f sho event, it e Medical Examiner must be redfind at Md. P.G. Upper Marlboro 1 TXes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4330 Canyonview Drive 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.Trade Elementary/Secondary (0-12) College (1-4or 5+) Representative Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron W. Coleman Geneva Washington ٩ <sup>19a.</sup> Informant's Name/Relationship (Type. Print) husband Michael D. Simms— 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4330 Canyonview Dr. Upper Marlboro, MD.20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State Harial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CheltenhamVeteran Jan27,09 Cheltenham, MD 20001 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RobinsonFuneralHome13136thSt.NWWashDC bolin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Lun Adminud disease or condition resulting in death) Unkriswas /Medical Due to (or as a consequence Examiner 47Know-Due to for as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1∐Yes 2⊠No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🔀 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 24 hours af e Funeral D letely filled in X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

CR B

State 31. Date filed (Month, Day, Year)
Registrar
JAN 1 8 2009

32. Registrar's Signature

M.P.

M.D

anhite

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROINTAN FARAHIFAR

9801 Georgia

1243446

1.15.09

3-32 Silver

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 10, CORA LEE DAVIS SNYDER 2009 23:04 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGES CLINTON If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 10-01-1931 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 21 F 246-46-1167 N.C. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at XX Yes 2 No Director MD PRINCE GEORGES CAPITOL HEIGHTS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 5020 DOPPLER STREET 20743 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XXNo BLACK ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SILVER AND GOLD SMITH MID ATLANTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental WALTER ARTIS CORA EDMONDSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5020 DOPPLER STREET CAPITOL HEIGHTS, MD 20743 HERBERT SNYDER/ HUSBAND or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it
any injury or o ¥Burial 2 ☐ Cremation 3 Removal FORT LINCOLN 01-16-2009 BRENTWOOD, MARYLAND 4 Donation >5 Other (Spec 22. Name and Address of Facility OHN T. RHINES FUNERAL HOME 3005 12th STREET N.E. WASHINGTON, DC 20017 Signature of Funeral Service I Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line Approximate Interval Between Onset and Death Immediate Cause (Final tantin **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hear nimed to the Funeral Director. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

31. Date filed (Month, Day, Year) State JAN 1 8 2009 Registrar

29b. Signature and

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1328 Jonthem arine JE Jute 310 Washinghan

MUD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

29c. License number

D0055120

29d. Date signed (Month, Day, Year)

2009

09-00430 Deborah Schumpert

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 02636

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DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAGTA SACH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible 174, Fostice All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 11:53 14, James Perry Strine January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 XM 2 □ F 64 June 30, 1944 Maryland 015-38-7897 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Frederick Brunswick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14 West G. Street 21716 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2 TXNo Specify: Specify: White 3 Widowed 4 😾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Fork Lift Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Cleckner Beatrice Barger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14 West G. Street, Brunswick, MD 21716 Earl Strine / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/2009 Frederick, Maryland Resthaven 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 23a. Part / Enter the disease, or complication was caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1100 North Maple Ave., Brunswick, MD 21716 Approximate Interval Between Onset and Death BARACH NUID Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARMAL INFARCTION 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 N 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?

1☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760 signed by t be detach cate has I page 2 s this certificate

After the

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

Completed by

Be

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ent, the Medical Evan from that be notified at

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygienn Important: If item 27 is marked other the any Injury or other traumatic event, ITEM 2006.

Physician

/Medical

Hospital or Attending death. ieral Director fter To the Hospital within 24 hours

Certification: To ☑ Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Momicide 29a. Certifier Medical

31. Date filed (Month, Day, Ye

and manner stated.

28b. Time of 28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signatur

29d. Date signed (Month, Day, Year)

30. Name are address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave., Takoma Park, MD 20912 Piotr Wyrwinski, MD

Registrar

Darks

			1 – For State Registrar	State of Ma	ıryland				lealth a Death	and M		giene Reg. No		9 (	02639
	Physici	an	1. Decedent's Name (First, Middle, La	ist)					-		2. Date of Dea	ath Da	y Year		Time of Death
	/Medic		HILDA RA		DA						01	16	2009	1 /	2:41 PM
	Examir	ner	4a. Facility Name (If not institution, given		. 1		4b. City		r Location o シ <i>ロム</i> /シ		,	4c.	County of De	•	
	Funeral	_	FENINSULA RESION  5. Social Security Number 6.5	1.4.0.1	(In yrs. las	nTCV st birthday)	If Unde	er 1 Year	If Under	/	8. Date of Birt	h	9. Bi	rthplace (	State or Foreign
	Director		218-03-9829	1□M 2\\ F	89	Yrs.	Months	Days	Hours	Min.	(Month, Day October 2	y, Year)		cvlan	_
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	be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the "hodical Eventhar must be routled at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Dec	edent of H	fispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi		dian,
36	s afte	by Fu	1 Never Married 2 Married	1 □Yes 2 📉 N If Yes, Give	lo		1 □Yes		Specify:	,			Specify:	Whi	± 0
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215	e. In "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5-		(Give	kind of w	ork done ouse retired	durina most	t of worki	ng	100.10	ind of Edsilles.	5/ III dusti y	
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П			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	pplications that caused one cause on each lin	the death.	Do not ent		_			r respiratory ar	rest,		Inter	oximate val Between et and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	K-E	NAL		TAIL	URE						
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Ξ	dis ys	<b>m</b>	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 E	R/Outpatier	nt 3∏ [	OA Oth	or:		r (Check only or me 5 ☐ Resid		6 □Other /Sn	necify)	
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			30. Name and address of person who	completed cause of de	eath (Item 2			and .	10.1			-1	,	. 3-	- k1
	Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	75 E/	45/E	an,	SI-WKE	OR	- SAL	15/5	URY 1	WP C	1804
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 02640 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 19, 2009 January 2:00 A <u> Anastasia Romanova Summers-Roma</u> /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince Georges 19 Post Office Avenue #104 Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept 12, Birthplace (State or Foreign Country) **Funeral** 1974 Days Hours Months 107-76-1925 1 □ M 2 □ ₹F 34 Sept Director Canada Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examins must be notified at 1√2 Yes 2 □ No Director MD Prince George's Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19 Post Office Avenue #104 20707 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Actor/Model/ Make-up Artist Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MacDonald Carlyle Summers-Roma Helen Sharon Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Sharon Jones/mother 19 Post Office Avenue #104 Laurel, MD 20707 : If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State W. Arundel Crematory | 01/20/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service L MO1251 Reverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the discrase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JLIOBLASTOMA MULTIFORME years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I δ 1 Tes 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1550 Orleans St. Room 1M16 Baltimore, MD 21231 Clare Ferrigno, CRNP Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Division of Vital Records, P.O. Box 68760,

			For State Registrar	Jugo 1	-			d / Depa		t of H	lealth a	and N	Mental Hy		/ H H Q	0261	.
	Physici /Medic		Decedent's Name (First, M.     ANNIE LEONA	STEVE	ENSON								2. Date of D Month 01	26	2009	3. Time of D	
£75.	Examir Funeral	er	4a. Facility Name (If not institute FROSTBURG VI 5. Social Security Number	LLAGI 6. Sex	E NURS	ING C		TER last birthday)		STBU	If Under		8. Date of B	irth	County of Dea ALLEGAN 9. Bir		Foreign
	Director		217-10-7151 Usual Residence of Decedent 10a. State 10b. Cou	***	]M 2 <b>2</b> 47F		)4 0c. City	Yrs. y, Town or Lo		Days	Hours	IVIII t.	10-27-	1914	FRO	TBURG, I	MD
	th the Mary or 28a-f sh	Director	MD ALLE	GANY			FRC	OSTBUR	10f. Zip	Code				10g. Cit	lizen of Whal Co	1 Yes 2	No No
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Madical Examinatment he notified at	by Funerai	93 WALNUT ST  11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divor	larned	12. Was Dec Armed F 1  Yes If Yes, G Year or E	orces? 2 No ive	ər in U.		215: Was Deced if Yes, spec	ent of H			ecify Yes or N Rican, etc.)	U.S.	14. Race - Ame Black, Whit		
Maryland 21215-0036	od within 72 ho giene. er then "natur , the Madical	Completed	15. Dece (Specify only hig Elementary/Secondary (0·1 12		e completed)	) (1-4or 5+)			dent's Usua kind of woi DO NOT us MEMAK	k done d e retired	ation during mos	t of work	ing		ind of Business	ŕ	
ryland	should be fited and Mental Hygie marked other umatic event, II	To Be (	17. Father's Name (First, Midd TIMOTHY TAYLO 19a. Informant's Name/Relati	R ATI				19b. Maili	ng Address	(Street a	EVA	HAW	e (First, Middle  CINS AT  al Route Numi	HEY	or Town, State,	Zip Code)	
Baltimore, Ma	Pages 1 and 2 nent of Health an int: if item 27 is iry or other trau		MARY LYNN PEC  20a. Method of Disposition  1  Burial 2 Cremative 4 Donation 5 Othe	on 3 □R	AUGHTE		C		7 UPPI esition (Nam matory or o	ER G	EORGE	S CE	REEK RD	20c. Lo		RG, MD 2: Town, State	1532
Balti	permit. Pages Department of Important: If it any injury or c		21. Signature of Funeral Serv	b S	ر منافعات		005	47 161	. Name an	d Addres	SI.,	SOV FRO	VERS FU OSTBURG	NERAI	L HOME,	P.A.	
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P.O. Box 68	Attending Physician: The law requires that the death certificate be executed in death.  sctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	2		birth 2 (	] F <i>e</i> tal	Ideath 3	Ectopic pri Other (sp						23d. Date of de Month	ivery Day Ye	ar
Records, P	w requires that been signed to should be detailed		Part II. Other significant cond					ulting in the u		iuse give	en in Part I.			tobacco (		the cause of dea obably 4 SUni	
Vital Rec	ysician: The law is certificete has bi director, page 2 st	e Completed	25. Was case referred to med	ical	,								peri 1 Yes	opsy ormed? 2 \( \text{No}	prior to death?	utopsy findings av completion of cau	ailable se of
Division of Vil	nnding Physicia ath. n: After this certi ne funeral direct	ToB	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Per 2 Accident inv	eding estigation	_	Inpatient of Injury oth, Day Y		ER/Outpatier 28b. Time o Injury		Bc. Injury Work	er: 4 Nu	irsing Ho	h Check only ome 5 ☐ Res 28d. Describe	id <i>e</i> nce	6 □Other (Spe	cify)	
DIVIS	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 ☐ Homicide det	uld not be ermined	build	ding, elc. (	Specify						City or To	own, State	9)	Iral Route Numbe	ır,
	To the Hospital or within 24 hours afte to the Funeral Dir.	Medical	29a. Certifier (Check only one) 2 Medi	al Examii	ner: On the t	e best of n basis of ex nner states	amina	wledge, deat tion and/or in	vestigation,	in my of	ne, date an pinion, dea e number	id place, ith occur	and due to the red at the time	, date and	and manner as d place, and due te signed (Mont	to the cause(s)	
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**Physician** /Medical Examiner law requires that the death certificate be executed and burial-trar Records, P.O. Box 68760,

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Important: If Item 27 Is
any Injury or other treu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rel", or items 23a or 28e-f show Examiner must be notifled at

and 2 should be filed within 72 hours after death with itealth and Mental Hygiene. To 7 is merked other than "neturel", or items 23a or 3

Baltimore, Maryland 21215-0036

Directo

Funeral

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Be

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attending physician for use as the buria detached pe page 2 director, this funeral After by the

Physician: or Attending death. after death Director: 24 hours after e Funerel Dire letely filled in b Hospital within 2.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure Peripheral Vascular Disease Hypertension 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 12,2009

Division or Vital

State Registrar

31. Date filed (Month, Day, Year)

JAN 16 2009

Victor Onyejiaka, M.D.

7325A Hanover Parkway, Greenbelt, Maryland 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 02643 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19<sup>Day</sup> **Physician** Month 3:40 P M Banks H. Talley 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 42 Brandywine Dr. Ocean Pines
If Under 1 Year | If Under 24 Hrs. Worcester 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day Year) 5/5/1923 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 85 Days Hours Min. 225-28-9728 V٨ Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 Brandywine Dr. 21811 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No <u>გ</u> Specify: Specify: 3 ₩ Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Director Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William A. Talley Elizabeth Joyner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Swade / daughter 134 Nentego Dr., Fruitland, MD 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 1/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CVA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as e consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown DM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed PVD 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 🔼 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 [XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066169 1/20/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 6+1 Angela Gibbs, MD 10445 Ocean City Blvd., Berlin, MD 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 Registrar

DHMH 17 Rev 1/2001

		For State		aryland / Dep		Health and N	Mental Hyg	iene		
		Registrar		CE	Tillicale of	Dealli	Т	eg. No20		
Physici /Medic	_	1. Decedent's Name <i>(First, Middle, Last)</i> Tshikangala Tshitundu					2. Date of Deat Month January	h Day 12	Year 2009 3. Time of Death 1:46 p M	
Examin		4a. Facility Name (If not institution, give	4b. City, Town, or Location of Death			4c. County	of Death			
		Holy Cross Hospital			Silver Spring			Montgomery		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   Months   Days   Hours   Min.   (Month, Day, Year)			Year)	9. Birthplace (State or Foreign Country)	
Director		5/9-15-2951	EIW ZUF	58 Yrs.			December		Dem. Rep. Congo	
pu		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits	
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he M	Director	Maryland Montg	omery		S1. J	ver Spring	1.1	0g. Citizen of V	What Country?	
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72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Ocal Exprimer must be redified at	Funeral	11413 Gilsan Street  11 Marital Status 12. Was Decedent Ever in U.S.							emocratic Republic Congo  14. Race - American Indian,	
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lid be denta rked tic e	To E	Luabeya Tshitumbi					Bilonda Musuamba			
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and 2 salth salth 27 i		Delphine Tyson - W	life	114	13 Gilsan S	street, Silv	er Spring,	Maryland	d 20902	
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permit. Pages 1 ar Department of Hec Important: If Item any Injury or othe		21. Signature of Funeral Service Licensee 22. Name and Address of Facility								
88E # 8	0. 1	Myelin T. Webert Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904								
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hysl this o	Certification: To							ome 5 Residence 6 Other (Specify)		
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To the Hospital or Attent within 24 hours after thous after describe the Funeral Director: completely filled in by the										
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
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F. ≥ 5 8	_	7	7.1	7	D521270			-		
>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
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Sta	nto.	Cheryl Aylesworth		ar's Signature		, wheator	, maryiano	20902		
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Registrar

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		For 1 _ State	State of Maryland	•			lental Hyg	iene			. –
N		Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Death	2. Date of Deat	eg. No.2 0	09	0.26	45
Physicia							Month	Day	Year 109	4:06	ъМ
/Medic Examin		Gail Lavinia Turnbo 4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Death	January	4c. County (			
		Shady Grove Adventi			Rockvill			Montgo			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Cou	place (State or I ntry)	Foreign
Director		077-34-5368 Usual Residence of Decedent	66				Aug. 26	, 1942	Virg	inia	
aryland show	_	10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City 1 ☐ Yes 2	
he Ma 28a-f	Director	Maryland Frederick  10e. Street and Number	Moun	t_Airy	10f. Zip Code		1	0g. Citizen of W	/hat Cau		AINO
with t		13586 Old Annapolis	Court		21771			JSA	mai cou	intry:	
death	Funeral		2. Was Decedent Ever in U.S Armed Forces?	S. 13.		lispanic Origin? (Sp an, Mexican, Puerto		14. Race	- Ameri k, White	can Indian,	
s after , or Ite	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2 <b>X</b> No	Specify:		Specify:		, Gio.	
tural'	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	16a. Dece	dent's Usual Occup	oation		16b. Kind of Bu		nite ndustry	
hin 72 e. an "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of work d)	king			-	
led wit lygien ner tha	5	12		Bookk	ceeper	do Markada Nam	* (Final Bainlette A			dealers	hips
d be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam		viaiden Surnami	e)		
should be filed within 72 hours after death with the Maryland and Mental Hyglene. I marked other than "natural", or Items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ဍ	James C. Ping  19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailii	ng Address (Street	Olive Wa and Number or Ru	Idruff ral Route Number	; City or Town,	State, Zi	p Code) 217	
and 2 ealth a n 27 is er trai		Michael Turnbow, hu	ısband	1		apolis Co					, ı
Pages 1 nent of He nt: If iten		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Re		ace of Dispo emetery, crei	osition (Name of matory or other plac	ce)	Date	20c. Location -	City or T	own, State	
		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lease	Meti	copoli	tan Crema	atory 1/1 ess of FacilityMo1	4/2009 A	lexandr	ia,	Virgini	la
permit. Departr Importa any Inju		Hima W. De	us-			e Road, D				111eral 1 20872	iome
N. S. P.		23a. Part1. If ter the disease, or complice shock, or heart failure. List only one	atio that caused the death	. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between	en
Physician	1	Immediate Cause (Final disease or condition resulting in death)	Lung Cancer							Onset and De	eath
/Medical Examiner		resulting in dealth)	Due to (or as a consequ	ence of):							
*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):							
e executed ian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last									
be exe	_	resulting in death) Last	Due to (or as a consequ	ience of):							
eath certificate be attending physici for use as the bu	edic	d.									
th certi	M/us	23b. was decedent pregnant	c. if yes, outcome pf pregnal		⊒Ectopic pregnanc	v		23d. Date		-	
Attending Physician: The law requires that the death certificate be death.  ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu	by Physician/Medica	in the past 12 months? 1 □ Yes 2 🏿 No 9 □ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)	,		Mor	nth	Day Ye	ar
w requires that the debeen signed by the should be detached	F.	Part II. Other significant conditions conti	ributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contr	ibute to	the cause of dea	ath?
quires n sign uld be	g b	Rheumatoid Arthriti	is				1 □ Y	es 2□No	3 X Pro	bably 4 □Un	known
law re as bee 2 sho	plet						24a. Was a	n 24b. V	Vere aut	opsy findings av	ailable
sician: The lav certificate has rector, page 2	Completed						perform	ned? d	leath?	2□ No	
sician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🔀 Inpatient 2 🗆 I	ER/Outpatier	nt 3□ DOA Oth	26. Place of Dea					
g Phy er this	n: To	27. Manner of Death	28a. Date of injury (Month, Day Year)	28b. Time o		ry at	ome 5 Reside			17/)	
endln eath. or: Aff	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World)	injury		Yes 2 □ No					
or Att after d Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, sti	reet, factory, office		28f. Location (St City or Town		er or Rui	al Route Numbe	∍r,
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1X Certifying Physi	cian: To the best of my know	wledge, deat	h occurred at the ti	me, date and place	, and due to the c	ause(s) and ma	nner as:	stated.	
To the Ho within 24 l To the Fu complete!	Medical	(Check only 2 Medical Examination)	er: On the basis of examinat and manner stated.	tion and/or in							
Vith Vith COT	Σ	29b. Signature and title of certifier	Principality (Sept.		29c. Licens	se number	2	9d. Date signed	(Month	, Day, Year)	
(12)		30. Name and address of person who con	nnleted cause of dooth (item	23a\ /Time	D6223	4		Tanuary	13,	2009	
(10)		Manish Agrawal, 970	7 Medical Cer	iter D	rive. Roo	ckville.	Marvland	20850			
Sta		31. Date filed (Month, Day, Year) 5 20	32. Registrar's Signat	ture /	barre		y . cant				
Registr	ar	O/111 = 0 20	1	1 17	, ,,,						

Certificate of Death

1. Decedent's Name (First, Middle, Last)

**Physician** 

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9009 Ewing Drive Bethesda, MD 20817 20c. Location - City or Town, State Odenton, MD Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 1 week 1 month 6 months 10 vears 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 XNo 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) January 16, 2009 Brent Cole, M.D. 5530 Wisconsin Ave. #700 Chevy Chase, MD 20815

Reg. No.

16,

2009

14. Race - American Indian,

Asian/Pac. Am.

Black, White, etc.

4c. County of Death

1922

10:45 AM

9. Birthplace (State or Foreign Country)
India

10d. Inside City Limits

1 ☐ Yes 2 No

Date of Death
 Month

Registrar

31. Date filed (Month, Day, Year)

JAN20

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00662 State of Maryland / Department of Health and Mental Hygiene Juliana Vigil-Bran 2009 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day January 22, 2009 Vigil 0830 hrs Juliana Patricia Grande **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Hvattsville Montgomery M855 Unit Field P-4 by Online Physician If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours: Min. Director Country Maryland M 2X F 05/08/2007 Yrs none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 No 28a-f show once. Maryland Prince Georges Hyattsville the Maryland Director 10a. Citizen of What Country? 10e. Street and Numbe 10f, Zip Code notified at 20781 U.S.A. 4003 Jefferson St. 23a Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? White, etc. 1 X Never Married 2 Married - death Yes 9 Specify: White Yes 2 No specify: Salvadorian f Yes. Give Year hours after Widowed Δ Divorced the Medical Examine ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 7 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Gilberto Rodriques Be Vigil Zucena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Department of Health and N Important: If item 27 is n injury or other traumatic 4003 Jefferson St. Hyattsville, MD 20781 Gilberto Rodriques (father) 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation Removal from State Jan.26,2009 Hyattsville, MD Geo. Wash Cemetery Donation 5 Other Specify: 22. Name and Address of Facility ative of Funeral Service License Rendon/Hale Funeral Home 8 Lanham, MD 20706 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death Sudden unexplained death in Childhood (SUDIC) Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical #1 as noted, 23a, 2/, 28a-t, perME, g891 5/22/09X UNPENDED X AMENDED the attending physician and for use as the burial -Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Dav Year Live birth Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28d. Describe how injury occurred 28b. Time of Injury

After this certificate has the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifi Division of Vital

Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 27. Manner of Death Yes 2X No Natural Pending 3/22/09 Fd 0730 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4003 Jefferson St Greenbelt, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide residence Greenbelt, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month) 32. Registra

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

111 Penn Street, Baltimore, MD 21201

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

January 23, 2009

State Registrar

within 2

29b. Signature and title of certifier

PL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TTEM#30perDVR, G888, 2/2/09, WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26 2009 **Physician** CORDELL VINSON **JANUARY** 11:08 AM CHARLES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL PR. GEORGE'S CLINTON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) MAR. 22, 1949 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min **X**M 2□ F TENNESSE 212-54-0360 59 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the motified at 1 ☐ Yes 2X No Director MD CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2230 BRIDLE PATH DRIVE 20601 U. S. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: WHITE à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE ENGINEER SMITHSONIAN INST. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISACC ARLESS VINSON VIRGINIA WHITE ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce. KATHLEEN VINSON/WIFE 2230 BRIDLE PATH DR. WALDORF, MARYLAND 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JANUARY Nation | 2 □ Cremation | 3 □ Removal from State RESURRECTION CEM. 31,2009 CLINTON, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the f after death 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 26-00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

V

State

Wendell C. Pierson
31. Date filed (Month, Day, Year)

FEB 0 2 2009

32. Registrar's Signatu

Southern Maryland Hospital Clinton, MD. 20735

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Mar	yland / Depa	artment of H	lealth and N			02649
			State Registrar		Cei	rtificate of	Death	Re-	g. No.	3. Time of Death
	Physicia /Medic		Decedent's Name (First, Middle, I      Donald Edward I	Vyan†		45 City Town	and another of Dooth	January	Day Year 20, 2009 4c. County of Death	5:20 A M
	Examin	er	4a. Facility Name (If not institution, g			Clear S	or Location of Death		Washingto	on.
	Funeral		13002 Spickler   6 5. Social Security Number   6		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		234-58-9759	1X)M 2□ F	70 Yrs.	Months Days	Hours Min.	Nov. 1,		Virginia
	P ≥		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	ocation			1	0d. Inside City Limits
	danyla shov	ō	Maryland Washin		Clear Sp					1 ☐ Yes 2 💢 No
	the A	Director	10e. Street and Number	91011	Crear Sp	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	3e or		13002 Spickler R	oad		2172	2		USA	
	death	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	or the		1 Never Married 2 X Married	If Yes, Give		1 ☐ Yes 2 ☑ No			Specify: Whi	+6
Ö	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Marical Examinar must ke molified at	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business/In	
15	n ne	piet	(Specify only highest s Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of work	ting		
212	e filed within al Hygiene. other then vent, II e Ma	Com	12		Sale	sman	,		utomotive	Tools
nd	be filed within 72 hours after death with the Marylan hal Hygiene. Id other then "neturel", or flems 23e or 28e-f show or other then shelpes Examiner must be redified at	Be (	17. Father's Name (First, Middle, La	st)				e (First, Middle, M		
yla	should be ind Mental s marked umetic ev	ို	Ray Allen Wyant	(Time Dilat)	10h Maiti	an Address (Caras		ane Simms	City or Town, State, Zip	Cadal
Mar	d 2 th a 7 ls		Shirley M. Wyan	, ,, ,		2 Spickle			Spring, MD 2	
ē,	Health tem 27 tem 27		20a. Method of Disposition		20b. Place of Dispo			-	Oc. Location - City or To	
E O	Pages ent of nt: If I		1 ☐ Burial XXCremation 3 14 ☐ Dopation 5 ☐ Other (%)				· .	1-2009 S	Smithsburg,	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Importent: If Item 2 eny Injury or other once.		21. Signiture of Juneral Scale U	ens		2. Name and Addre	manufacture of the second seco		eral Home,	
m	8 8 E 8 8		Might	×6	4	25 S.Cond	ococheagu	e St. Wil	liamsport.	MD 21795
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the constant in the co	ne death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Prysician	9.3	Immediate Cause (Final disease or condition resulting in death)	_a/X/Y	gio/cla	oxe a	4016	RUDO	rec	your
	/Medical Examiner			Du∜to (or as a	consequence of):				'	
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9 x	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of deliv	erv
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2 4□Pregnant at ti		⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		Month	Day Year
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s, P	es tha igned be del	by P	Part II. Other significant condition	s contributing to death but	not resulting in the t	ınderlying cause gr	ven in Part I.		acco use contribute to t	
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lec	has b	Completed	Const Tailus	e, coy	estille	hert	Tailue	24a. Was ar autopsy perform	prior to co	ppsy findings available impletion of cause of
			coronor are	discase	· Dia	Leter Na	11/2/pa	1 □ Yes 2	No 1 □ Yes	2 No
Vital		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital: 1  Inpatient	t 2 ☐ ER/Outpatie	nt 3□ DOA Ot	hor	th (Check only one	nce 6 🗆 Other (Specia	6()
of	y Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time o			28d. Describe ho		<i>y</i> /
ion	ttending F death. ctor: After / the funer:	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Year) Injury		Yes 2 □ No			
Division	of or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or Run , State)	al Route Number,
D	Hospitel or Attending 24 hours after death. Funerel Director: After stely filled in by the fune								(2)	total .
	To the Hospitel or Atwithin 24 hours after of To the Funerel Direct completely filled in by	Medical		Physician: To the best of and manner state	examination and/or in					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	5		29c. Licen	se number	29	d. Date signed (Month,	Day, Year)
	F>F0		1/1/10	<b>イ</b> ノ		D	26 806	5 5	anwa 21	2009
0 7	11 -		30 Name and address of person w	no completed cause of dea	ath (Item 23a) (Type	. Print)	[.]	1 .	D 2/14	()
9	H-3		31. Date filed (Month, Day, Year)	32. <b>J</b> egistrar	's Signature	we.	1 teges	Aun 14	11 <119	_
	Sta Regist	ate rar	JAN 22	2009 January	~ B. A	back	<i>U</i>			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Roselle Mary Wooten January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** rincess Anne Manokin Manor Somerset 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/6/1912 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2**X**□ F 215-44-6425 96 **Director** MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertal Hygiene. In the file may 2 is an and-red other than "natural", or items 23a or 28a-f show any or other traumatic event, its Medical Exprinter mast be rotified at any or other traumatic event, its Medical Exprinter mast be rotified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Milldale Dr. 21804 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. rmed Forces? ☐Yes 2 XNo 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. ģ Specify: white 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sewell H. Bradford Laura M. Jarvis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Ball /daughter permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tr once. 114 Potomac Ave., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Riverside Cemetery 1/21/09 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Preyow 40) signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Arter this certificate has been si funeral director, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗌 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 047094 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAY 5. DIVISION 1415 SACISOVY 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Barbara Wainwhight 08 : 53 AM 16 2009 January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore University of Maryland Medical (enter If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 54 Yrs. 8. Date of Birth 7/14/1954 Birthplace (State or Foreign Country) MD 5. Social Security Number Days Hours Min. 1 □ M 2**X** □ F MD 214-74-6369 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7948 Bethel Rd. 21874 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 ∐Yes 2 ∑XNo 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify. Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Care Giver Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Floyd Lewis, Sr. Annie Virginia Bowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Wainwright / husband 7948 Bethel Rd., Willards, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity United Cem. 1/22/09 Newark, MD 22. Name and Address of Facility Burbage Funeal Home 21. Signature of Funeral Service Li 108 William St., Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myelogenous

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show amy liqury or other traumatic event, the "Modical Examinations is not the angle.

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

**Funeral Director** 

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Completed

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signed by the attending physician and I be detached for use as the burial-trar certificate has t rector, page 2 s this within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examine Be Completed by Physician/Medical Medical Certification: To

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Apergills Pact Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	monia	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy ther (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical	I.	26. Place of Death	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Matural  2 Accident  3 Suicide  4 Homicide  5 Pending investigatic 6 Could not l determined	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28b. Time of Injury	28c. Injury at Work?  M 1 □ Yes 2 □ No	3d. Describe how injury occurred  3f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death or aminer: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place, a tigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

1457481947

January 16 2009

BA 10

State Registrar AShley Wer 31. Date filed (Month, Day, Year) Wermine

JAN 20

MD 22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimort, MD 21201

32, Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Carolyn Huddle Wells January 12. 2009 11:50 P M /Medical 4a. Facility Name (If not institution, give street and number) 632 Wilson Place Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/10/1922 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min Months 1 ☐ M 2 ☐ F 86 Yrs. Director 579-32-5925 Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director MD Frederick 1 Tryes 2 □ No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 632 Wilson Place 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 K No Specify. þ Specify: White 3 ☐Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the M 2008. Elementary/Secondary (0-12) College (1-4or 5+) <u>Art REsearch Assistant</u> Art Gallery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerome Klahr Huddle ဂ Carolena Heiby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Wells / Son 2327 Eastern Ave. Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State National Crematory 1/15/2009 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility oseph Gawler's Sons Inc. 21. Signature of Funeral Service Lig 5130 Wisconsin Ave. NW Washington, DC 20016 Willia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC COLON CANCER DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Aesidence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) MD Name and address of person who completed cause of death (Item 23a) (Type, Print) Stc H-4 Frederick, mb SHFFAR TOIL HOUSE Ave 31. Date filed (Month, Day, Year) State 5 Registrar

09-00292										
Wilma	Williams									

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Division pital or Attendi ours after death. reral Director: /		Suicide Homicide	6 Coul	d not be rmined	28e Pla	-	y - At home	, farm, stre	et, factor	y, office bu	uilding, etc	281	. Location (St or Town, Sta		Number or F	Rural Route	Number, City
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<b>3</b>	30	. Name and addre	111	Who co	mpleted ca	use of dea	th (Item 23s		1	O.C.N	vi. ⊑.			variud	y : I, ∠U(		
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Star Registra	te <sup>31</sup> ar	. Date filed <i>(Monti</i>	h, Day Year	2009	Cen	Registrar's	Stgnature	park	2)								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Harold Odell Washington State of Maryland / Department of Health and Mental Hygiene 2009 02654 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ . Decedent's Name (First, Middle,Last) Month Day January 21, 2009 Ode11 Washington 2015 hrs Harold **Medical Examiner** c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Fort Washington Park Reserve Area "C' Fort Washington If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Days Hours Country Virginia Directo 1945 231-58-7145 Oct 28, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County District of Columbia Washington 1 X Yes 2 No 28a-f show notified at once. with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20019 632 Chaplin Street, SE United States 14. Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Pages I and 2 should be filed within 72 hours after death variet of Health and Mental Hygene nent of Health and Mental Hygene art. If item 275 is marked other than "natural", or item and other tranmatic event, the Medical Examiner must b Armed Forces? Never Married 2 X Married 1 X Yes Specify: Black Yes 2 X No specify: If Yes, Give Year Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than "ic event, the Medical 2 years MD 21215-0036 Electronics Technical Supervisor Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Washington Thomas W. Carter Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 632 Chaplin Street, SE Washington, DC 20019 Mary Washington - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Baltimore, 20a. Method of Disposition crematory or other place) Important: If it injury or other t Removal from State 1 X Burial 2 Cremation 3 permit Page Department 2009 Triangle, VA Quantico National Cemt. Feb 5. Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee Stewart Funeral Home, Inc. 20019 4001 Benning Road, NE Washington. DC 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death Exsanguination Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): b. Erosion of dialysis shunt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): pue PI line a-b, PII,27,28a-f, perMe, G888 2/4/09 Physician/Medical X UNPENDED AMENDED attending physician for use as the burial The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions à Yes 2 No 3 Probably 4 ✔ Unknown End stage renal disease Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 Yes this certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Other: examiner? Residence 6 Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury subject bleed from dialysis Certification: Natural Yes 2X No Director: 5 Pending 24 hours after death. shunt Fd 1/21/09 Fd 7:50 pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) Fort Washington Par 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined P.G. (Specify) Reserve Area C, To the Funeral found in car Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 22, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

32. Registrar's Signature

Patricia Aronica-Pollak MD.

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 15 2009 9:30 P M Debra Y. Zirckel 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin 3. Date of Birth 1/6/1952 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Hours Min. Days Months 1 M 2 XF 57 MD 213-60-8074 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes X□No Ocean Pines Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 46 Windjammer Rd. 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2X Married 1 □Yes 2 🛚 No Specify. white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Wagner Earl Yingling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Zirckel / husband 46 Windjammer Rd., Ocean Pines, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/16/2009 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur / f Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IXX hos Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

**Physician** /Medical Examiner

attending physician and for use as the burial-trar

page 2 s certificate

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Certification: To

Medical

The law requires that the death certificate be executed

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Box 68760.

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Hospital or Attending Physician: 24 hours after death.

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**Physician** 

/Medical

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Examiner

**Funeral** 

Director

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Funeral Director

Completed by

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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "กลนเคล" กะ เล......

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Completed by Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an was an autopsy performed? 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yo

25. Was case referred to medical examiner? 1∐ Yes 21 No 27. Manner of Death

inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Natural 2 Accident 3 ☐ Suicide 4 \ Homicide

29a. Certifier

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ Nio

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number D006 4120 29d. Date signed (Month, Day, Year)

30. Nar and red dress of person who completed cause of death (Item 23a) (Type, Print)

Berlin Aatl 9733 Healthway Drive Zeeshan

State Registrar 31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND# liperMD1-15-09, BWW, MoCo Certificate of Death Reg. No. 2 2. Date of Death an 9, 2009
Month Day Year 1. Decedent's Name (First, Middle, Last) Month 6:10 AM **Physician** Bruno Peter Zanin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth May 1, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1**∑**M 2□ F 90 Pennsylvania 193-07-7181 1918 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations and injury or other traumatic event, If "Medical Examinations are also and injury or other traumatic event, If "Medical Examinations are also and injury or other traumatic event, If "Medical Examinations are also and injury or other traumatic event, If "Medical Examinations are also and injury or other traumatic event, If "Medical Examinations are also and injury or other traumatic event, If "Medical Examinations are also are also and injury or other traumatic event, If "Medical Examinations are also are also are also are also and injury or other traumatic event, If "Medical Examinations are also Greenbelt 1 Yes 2 No Prince George's Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20770 30 Lakeside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify White Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giustina Dapont Natale Zanin မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Lakeside Drive Greenbelt, Maryland 20770 19a. Informant's Name/Relationship (Type. Print)
Margaret D. Zanin -wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 1/13/2009 Silver Spring, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma 21. Signature of Funeral Service Licenses Maryland 20**7**05 Oproc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine distribute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Tue to the as a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🖂 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached to 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐Yes 2 No 2 **X**No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier January 10 2009

State Registrar

JAN 15 2009

30. Name and address of person

31. Date filed (Month, Day,

F0/

Year



who completed cause of death (Item 2Ba) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** February 5:19 pm 2, 2009 MaryAnn Arvey /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1028 Foxchase Lane
. Social Security Number 6. Sex FSSEX
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. 11/003/1942 Baltimore 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Mary land 1 □ M 2**X**□ F 66 Yrs. 215-40-5958 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene.

ther than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Evanther must be notified at once. 10a State 1 ☐ Yes 2 No **Funeral Director** Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number S. A. 1028 Foxchase Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: ò Specify: 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Loretta Krainer Edward Dembowczyk 2 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 Foxchase Lane Essex, Maryland 21221 Robert Henry Arvey, III 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial **2XX**Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 02/03/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) therosalensis Physician /Medical Due to (or as a consequence of): Examiner per fensio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 XNo Day Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 ☐ Unknown icate has been siç , page 2 should b 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐No Division of Vital Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1⊠ Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Reference of the filled in by the fulled in by th death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 00036951

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 10:50 **ANDREW** January VIRGINIA SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Baltimore 8820 Walther Blvd. #3514 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 👿 F Yrs. 94 218-40-0044 1914 Director Dec. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer rust be retified at any Injury or other traumatic event, the Medical Evantmer rust be retified at any Injury or other traumatic event, the Medical Evantmer rust be retified at any Injury or other traumatic event. 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8820 Walther Blvd. #3514 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: þ Specify: 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4 years Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Lewis Smith 2 <u>Katherine</u> <u>Yeager</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Andrew, Jr. 405 Prince George Street Laurel, (son) Maryland 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 2-2-09 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Mitchell-Wiedefeld Funeral 6500 York Road Baltimore, 23a. Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage **Physician** /Medical Due to (or as a consequence of). Examiner arric stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the pest 12 months? 1 Yes 2 No Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ Elbrillahorn, hyponatremia 1 Tes 2. No 3 Probably 4 Unknown vis certificate has been s director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Kidney discuse autopsy performed 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the f 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State

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inainia Andrew

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

Etosha

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

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Dixon

FEB 0 3 2009

Backer

29c. License number

8800 Walther Boulevard Parkville, MD 21234

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02659 Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 30,2009 9:20 PM lan. orence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examiner tayson Street Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth Month, Day, 6. 26. Social Security Number If Under 24 Hrs 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 ▼ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other than the last other than try or other traumatic event, Ite Medical Exemited must be notified a 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD 1 Mes 2 No Funeral Director itimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA ayson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) dary (0-12) College (1-4or 5+) Home maker Middle 18. Mothe s Name (First, Middle, Maiden Surname) Be ones laggie mD 21212 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. Baltimore, 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundhal Service 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner (Zheimer' Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death. aftending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 🗷 No 2 □No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 Tho Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1/A Natural 1 ☐ Yes 2 ☐ No rector: / by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ē within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Trace to044296 February 3, 2009 30. Name and a dr of person who completed cause of death (Item 23a) (Type, Print) 705 DIGITAL DRIVE, SUITE G MARIAN RUMGUANO, DO LINTHOUM, MD 21090 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 05ePh 723AM annery 2009 /Medical 4c. County of Death 4a. Facility, Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** commons Catonsville atoroville Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Manth, Day, 9. Birthplace (State or Foreign **Funeral** Year) Days Months 1**X** M 2□ F 40 20.05.9916 Yrs. 05/25/19/18 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mist be notified at once. Baltimone 1 XYes 2 ☐ No MD **Funeral Directon** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Rosedale 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo ò Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) - Armaments Maintenunce leth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) tonne tarris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore MD 21228 Stone Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD 02/03/09 Forest Garrison 4 Donation 5 Other (Specify) Youghn C. Greene Funeral SVO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Road Randallstown MD 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** V disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (piscase of indusy that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Miknown After this certificate has been so fineral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 1No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat e Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 2009 and address of person who completed cause of death (Item 23a) (Type, Print) Rd. ederick 31. Date filed (Month, Day, Year) 32. Registrar's Signat State 3 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 02661 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year HALVARD HADA HL 10:15 A M 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3122 Dunglow ROAD BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Year) 1 M 2□ F 217-50-5608 maryland 1947 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f shov saleal Examiner must be notified at 10 Yes 2 No DUNDALK Director SAUMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ROAD USA 31333 3129 Dung law by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICIAN Automotive 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HALVARD HADAKL ELIZABETH Hielen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ROAD AROL HAGAL Dunglaw DUNDALK, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place)

Boy View Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 5 Other (Specify) 4 □ Donation 21. Signature of Funeral Service license 22. Name and Address of Facility Willow Springer 2134 Balti. BRADU ASHION 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS 1 de Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Tyes 2 No 3 Probably 4 Unknown AURTIC ANEURYSM. 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No MYPERTENSION 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Macaidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖎 🛈 atural 5 Pending 1 Yes 2 No investigation 2 Accident

**Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iten

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar cate has been signed by page 2 should be detack after death | Director: within 24 hours a

Certification: To

Y

State Registrar

and manner stated. 29b. Signature and title of certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

WISEAVENUE

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2009

MD 2122

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DUNDALK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

207 M . D .. SETH

31. Date filed (Month, Day, Year)

3☐ Suicide

29a. Certifier (Check only

4 Homicide

32. Registrar's Signature

For

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ath	Reg. No.	ZU	U

Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exaciliar must be notified at once.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar			Cert	tificate of	Death	Reg	. No. 2	109	02662
)h a i a i		1. Decedent's Name (First, Middle, L	ast)	1-2	ersor	1		2. Date of Death Month	Day 🞝	Year	3. Time of Death
hysici: Medic/		dyme	Ca 19	va	ecsor	(		January	Rgh &	009	10. 02AM
Examin		4a. Facility Name (If not institution, g	ive street and number)	)		4b. City, Town, o	r Location of Death		4c. County	of Death	
		Good Samarita	n Hospita	al		Balt If Under 1 Year	imore If Under 24 Hrs.	Lo Data of Blath		O District	Colonia de Francis
uneral			Sex 7. Ag 1 ☐ M 2 💢 F	ge ( <i>in yrs. i</i> 89	ast birthday) _ Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		9. Birthpia Count	**
rector		220-14-0622 Usual Residence of Decedent		09			L	05 02	19		NC
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r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of	What Count	ry?
23a o	a	3540 Lynchest	er Road				21215		U	.S.A.	
S S	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. W	as Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		ce - America	
or it		1 Never Married 2 Married				□Yes 2 No	Specify:		Specif		
LEXT,	d by	3 ₩ Widowed 4 □ Divorced	Year or Dates:								
"nat	lete	15. Decedent's l (Specify only highest g	Education grade completed)		16a. Decede	ent's Usual Occup ind of work done	pation during most of work d)	ting	8b. Kind of B	usi <b>nė</b> ss/Indi	ustry
than	Completed	12th grade	College (1-4or :	5+)		Housewi			Н	ome	
other ent, I	Be C	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	e (First, Middle, Ma	iden Surnar	ne)	
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a flexifical Examinant must be undiffied at once.	To B	Thomas Powell					Edna Mo	oore			
mar	-	19a. Informant's Name/Relationship	(Type. Print) Daug	ahte	19b. Mailing	Address (Street	and Number or Rui	ral Route Number,	City or Town	, State, Zip	Code)
27 is		Gloria Anderso	n Gillia	m	3540	) Lynch	ester Ro	oad, Bal	tmor	e, Mo	21215
r oth		20a. Method of Disposition		20b. P	lace of Dispos	ition (Name of atory or other pla	ce)	Date 20	c. Location	- City or Tov	vn, State
ant: If		ty Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□ Removal from State cify)	Ki			Park 2/3	3/09 V	lood1	awn,	Md
y Injurie		21. Signature of Funeral Service Lic	ensee		22. M =	Name and Addre	ess of Facility	,			
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ould s								1 LJ Yes	2 No	3 Proba	ably 4 Unknown
as b	Completed							24a. Was an autopsy	24b.	prior to com	sy findings available apletion of cause of
page	Son							perform 1 □ Yes 2	d?,	death?	2 × 100
ertific ector,	Be (	25. Was case referred to medical examiner?	11			100		th (Check only one,			
this o	ပ္	1 Yes 2 No	Hospital: 1 Inpati	-7	ER/Outpatient	3 LI DUA		ome 5 Residen			)
After	ion	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inj (Month, Da	a <i>y</i> , Yea <i>r)</i>	28b. Time of Injury	28c. Inju Wor M 1 [	ryat rk? ]Yes 2□No	28d. Describe how	injury occur	rea	
tor:	icat	2 Accident investigati 3 Suicide 6 Could not	be 290 Place of In	iury - At ho	me farm stre	et, factory, office	1162 Z 🗆 140	28f. Location (Stre	et and Num	her or Rural	Route Number
Dire d in b	Certification:	4 ☐ Homicide determine	building, e	tc. (Specif	y)	04, 140101 31 011100		City or Town,	State)	oor or riorar	Trodo realison,
neral / fille			Physician: To the best								
To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner s		tion and/or inv	estigation, in my	opinion, death occu	rred at the time, da	e and place,	and due to	the cause(s)
To th	Me	29b. Signature and title of certifier	2-	1111	aui	29c. Licens	se number / /	/ 29	d. Date signe	ed (Month, E	Day, Year)
í		duesh	K. Im	Pur		0	3000	V-	ento	7 27	201
		30. Name and address of person wh	no completed cause of	death (Iten	1 23a) (Type, F	rint) 10-	1	41-9	1770	4 ,	
		3601 LOCK	Kacen,	Ble	0	Lalli-	3066 mole.	10-0	14)	!	
Sta		31. Date filed (Month, Day, Year)	32. Kegist	trar's Signa	ture.	arles					
Registr	ar	FEB 03	2009 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Ye ar **Physician** 30 AM 2000 ce Fe. /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Morrison Age (In yrs. last birthday 8. Date of Birth (Month, Day **Funeral** erion, Days 1 □ M 2 🖫 F Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 No 1 Never Married 2 Married 1 ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White 7 is marked other than "natural", o traumatic event, the Medical Expen-Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Segondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1Wh sor ၉ ord 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 19a. Informant's N Relationship (Type. Print) permit. Pages 1 and :
Department of Health
Important: If item 27
any injury or other tro
once. Baltimore. 20b. Place of Disposition (Na cemetery, crematory or c 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation ∄ □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rem. 21. Signature of Fundral Service Mensee vans 21111 23a. Part 1. Enter the disease of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List in long cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart 7 eas Physician 25% V 8 /Medical Due to (or as a consequence of): Examiner 10 4 eus tic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner law requires that the death certificate be execute sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Ilation 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy Hospital or Attending Physician: The certificate 1 ☐ Yes 2 🗆 No Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and file of certifier 29c. License number

State

DHMH 17 Rev 1/2001

Registrar

6301

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUNEIL 32. Registrar's Signature

Villiam D. Mc

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 260 Josephine Bolt Leora Jebruary c. County of Death 4a. Facility Name (If not institution, give street and number) 05e Frank If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/08/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In Days Hours Months 1 ☐ M 2/CXF 85 225-24-2131 NorthCarolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 🛣 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1309 Fuselage Avenue 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baxter Sheets Ada Sheets 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommie Bolt (Husband) 1309 Fuselage Avenue, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 02/06/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part.\* Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) to (or an a consequence of): Mon Sequentially list conditions, from List cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contribuling to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural

requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

5

Completed

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hyglens. Internation the state of

Physician

/Medical

Examiner

attending physician and for use es the burial-transit

signed by the a d be detached for

icate has been sig , page 2 should b

certificate I

After this

funeral director,

Examine

Physician/Medical

≥

Completed

Be

Certification: To

Medical

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

Baltimore, Maryland 21215-0036

To the Hospital or Attending within 24 hours after ueaun.

To the Funeral Director: Af

State Registrar

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

000 Franklin 31. Date filed (Months Day, - Year)

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ROWN 200 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ALTIMORE OSPI T If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 10 • 13. 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **X** M 2 □ F Months 214-50-0241 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Exacities rougt by notified at MD Director 1 **W**es 2 □ No YNN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 XYes 2 □ No Ves, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify ģ 3 Widowed 4 Divorced Blac Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) r's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. . Keurse Jumme MD 21207 Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Fune a Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** only /Medical Due to (or s a consequence of): Examiner RR 105 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy of Vital 1∐Yes 2.2TNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 🔄 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation 1 Tes To the Hospital or Attend within 24 hours after death. To the Funeral Director: 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 10

32. Registrar's Signature

PH

31. Date filed (Month, Day, Year)

PLACE

20215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02667 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 5:00 A M 01 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Monto ionner Suburban ethesda 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day) Months Days 1 □ M 2 💢 F 032.28.5242 02/02 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits Columbia Director MD Howard 1 □Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 21041 LISA Hesperus 5042 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Moves 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ò Specify: Back 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic event, Inc.) once. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Woody Ernestine Richards Wilkens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adrience Byrd Elkins Park, PA Mill Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WooDlawn, MD Vaughn C. Greene Funaral SVC 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Vau berty Road Randallstown MD21133 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □₩6 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 1 Inpatient Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Division of Vital Records,

aftending physician and for use as the burial-tran signed by the a d be detached for cate has by page 2 s this certificate or Attending Physician; within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral

**Funeral** 

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at

Physician

/Medical

Examiner

21215-0036

Baltimore, Maryland

BOAM

0

Medical Registrar

29a. Certifier

State

DHMH 17 Rev 1/2001

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

85 32. Registrar's Signature

AUFF

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo o o

		,	For State of Maryland / Departif	icate of L	Death		erie 2 U U 9	02668
	Physicia	'n	1. Decedent's Name (Flrst, Middle, Last)		2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Jerl E. Baldwin			2	2 2009	1201 PM
	Examin	er	^	. City, Town, or	Location of Death		4c. County of Death	1
and the same of th			FRANKLIN Square Hospital Center	ROSY	edale		Balti	more
	Funeral Director		232-48-1642 1StM 2 F 77 Yrs. M	Under 1 Year onths Days	If Under 24 Hrs. 8 Hours Min.	August August	9. Birth 23, 1931	place (State or Foreign intry) WVA
and	M		Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location	on.				10d. Inside City Limits
e Maryla	a-f sho	ctor		le Riv	ver			1 □Yes 2 No
ath with th	23a or 28 Iust be no	Funeral Director	1003 Orems Road		1220		g. Citizen of What Cou USA	ntry?
IN Jerib ビ d 21215-0036 filed within 72 hours after death with the Maryland	0, 1	þ	1 Never Married 2 Narried   12 Yes 2 No		ispanic Origin? (Speci n, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White, Specify: Wh	etc.
15-0	"natura	Completed	15. Decedent's Education 16a. Decedent' (Specify only highest grade completed) (Give kind	s Usual Occupa of work done d	ation furing most of working	16	6b. Kind of Business/Ir	ndustry
212 212 d within	Hygiene. ther than int, the M	omp	Elementary/Secondary (0-12)   College (1-40r 5+)	rician		II.	Electria	1
VIN land 2	other other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name (/			
arylan	nd Mental marked o matic eve	으 음	William H. Baldwin		Reb	ecca R	atliff	
Ld lary	and I		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ad	dress (Street a	and Number or Rural f	Route Number, (	City or Town, State, Zi	p Code)
iBald e, Mary 1 and 2 shoul	f Health and Mer Item 27 is marke other traumatic		Pauline Baldwin /wife 100	3 Orem	s Road B	altimo	re MD 21	220
(3ald Win Baltimore, Maryland	Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  1 □ Purial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition cemetery, cremator Holly Hil	n (Name of ry or other place 1 Ceme	etery 2/6	/09 20	oc. Location - City or T Baltimor	
Balt permit.	Departi Importa any inji once.		21. Signature of Funeral Service Licensee 22. Na Co	me and Addres ${\sf nnelly}$	s of Facility 300 Funeral	Mace Home	Ave. Bal of Essex	to, MD 21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	ysicían Medical		Immediate Cause (Final disease or condition resulting in death)  a. ACUTE prevent mont	tis				Onset and Death
	aminer		Due to (or as a consequence of):  Sequentially list conditions  b. 3 ronchog en ic (	carci	noma			
uted	dansit	Examiner	Sequentially list conditions, if any, heading to minimize a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):					
<b>60</b> , §		-	resulting in death) Last  Due to (or as a consequence of):		-			
<b>68760</b> tificate be e	physi	<u>5</u>	d					
	within 24 hours are used in.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ect 4 ☐ Pregnant at time of death 5 ☐ Oth	opic pregnancy ner (specify)			23d. Date of deliv Month	ery Day Year
<b>P.O</b> that the	detac	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause give	n in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ords	en sigr	ted by	Brain Metastasis			1 ☑ Yes	2 No 3 Pro	bably 4 Unknown
Division of Vital Records, I or Attending Physician: The law requires the after death	ate has b	Completed	C.O.p.D			24a. Was an autopsy performe 1 □ Yes 2 □	d?   death?	opsy findings available impletion of cause of
/ita	ertific ector,	Be	25. Was case referred to medical examiner?		26. Place of Death (C			
of \	this o		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3		4 LI Nursing Home	5 🗌 Residend	ce 6 □Other (Speci	fy)
inding F	T: After	ation:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury Work? И 1 □ Y	rat ? ′es 2 □ No	d. Describe how	injury occurred	
Divis lor Atte	Directo	Certification: To	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, for building, etc. (Specify)	actory, office	28f	Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
ie Hospita	le Funeral	Medical C	29a. Certifier  (Chack only one)  1	urred at the tim gation, in my op	ne, date and place, and place, and place, and place, and place, and place, and place are determined as a second control of the	d due to the cau at the time, date	se(s) and manner as a and place, and due to	stated. o the caus <i>e</i> (s)
To th	To th	ž	29b. Signature and title of certifier	29c License		29d	. Date signed (Month,	Day, Year)
			I he french		1846	2	2/09	
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	anklin	S. O	DR	Balt ma	21237
	State Registra	е	OR MARTIN J Shedidan 9090 FR		- TUCCO E			0,00

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amend #30 Perbyk 6888 2/03/09 In amend 1rem 18 per 16 8888 2/03/09 In amend 18 per 18 8888 2/03/09 In amend 18 per 16 8888 2/03/09 In amend 18 per 18 8888 2/03/09 In amend 18 per 18 8888 2/03/09 In amend 18 8888 2/03/09 In amend 18 8888 2/03/09 In amend 18 8888 2/03/09 In amend 18 8888 2/03/09 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician JEOTAR William ancique ,200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Nurshing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 09/21/1925 1 M 2 □ F Washington DC 84 83 219-18-8398 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1X Yes 2 No Director Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 21217 1352 N. Stricker Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. XYes 2 Yes, Give 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ Specify: African American 3 Widowed 4 Divorced Year or Dates Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Laborer 12th is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cladys Emily Banks Lillian Burke George William Burke, Sr. traumatic ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other tratonce. 5809 Gist Baltimore, MD 21215 Mary Burton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-05-2009 Owings Mills, MD Garrison Forest 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** omu monte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation atural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3+ Debra Sue WErtheimer 2434 W. Belvedere Baltimore ,MD 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFR 0 3 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 7:40p. 01 30 2009 Bailey Cleotus 0. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1**X** M 2 □ F 06 10 <u> 218-12-8419</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Pikesville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 U.S.A. 7706 Eden Roc Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self\_Employed Heating\_Oil 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Flowers Robert Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7706 Eden Rock Way, Pikesville, Md 21208 Beverly J. Bailey-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 22. Name and Address of Facility 2/7/09 Pikesville, Md 21. Signature of Funeral Service Licensee March F/H West b etz 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or held failure. List only one cause of each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer WCHIN S **WOState** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. East of noting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Company arter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 ☐ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) HOSPICO 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

**Examiner** P.O. of Vital Récords,

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran ģ After this certificate has the funeral director, after death. filled in by

**Physician** 

/Medical

Examiner

Director

by Funeral

Be Completed

**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event anone."

**Physician** 

/Medical

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

(Check only one)

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

24 hours completely To the within 2

State Registrar 29b. Signature and title of certifier W. CRNT 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) January 31,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brud. Tauson lausentown Mest

31. Date filed (Month; Day, Year)

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20c nerFh 6890 4/27/09 TT Startyand Department of Health and Mental Hygiene AMEND TTEM/20c perFH-889 1-5-4/09 WS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Clarence Ε. Baylor 10:20am 2009 01 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Nursing Home If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 **√**M 2 □ F Director O 80 MD 215-28-2819 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ?? is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Profical Examiner must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 5510 Nome Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade na Dispatcher Diamond Cab Company permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Baylor ဂ္ Clarence Baylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5510 Nome Ave, Baltimore, Md 21215 Rita Baylor-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) oc. Location - City or Town, State

Lyndon, Reisterstown, MD 20a. Method of Disposition Date Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 2/5/09 Randallstown, Md St. Lukes of Funeral Service License March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CardislasCu Diserse **Physician** /Medical e to (or as a consequence of): Examiner Sequentially list conditions, ir any, teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and burial-1 Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ъ Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown Ś signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 2 No 3 Probably 4 Onknown 1 Yes page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes 2 certificate 1 ☐ Yes 2 🖒 № 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82 31. Date filed (Month, Day, Year) Registrar's Signatur State FEB 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:31 A M Margaret Mary Baker January 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shangri-La Assisted Living Ellicott City Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Director 162-03-3542 91 July 20, 1917 Pennsylvania Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Nadical Examiner rust be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 4475 Montgomery Road 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: White à Q 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Matthew Smith Mary Gallagher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Cookson Daughter 1502 Grooms Lane; Woodstock, Maryland 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 2/3/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee M01050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** men /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to lor as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 r Month 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 🗆 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, ours after death. within 24 hours a

1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one)	2 Medical Ex	caminer: On the bas and manne	sis of examina	ation and/or ir	nvestigation,	in my opi	nion, dea	th occurr	red at the time	e, date and	d place, and d	lue to t	the cause(s)	
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12		30. Name and address	ess of person wh	no completed cause		n 23a) (Type,	Print)	1.1	-0.1	A.	C R	م الم	ino c	0		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 02675 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9:05 P BALSER 2009 JOYCE JANUARY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/02/1936 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 216-32-4860 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ∐Yes 2**V**□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3411 KESTON ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes X□No Specify: Specify: WHITE 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EDITOR **\$OCIAL SECURITY ADMIN.** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MORRIS RITZES MOLLY **GOODMAN** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARC BALSER / SON 3922 ROLLING ROAD, UNIT A7 BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND FRIEDEL LODGE 02/02/2009 ROSEDALE, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Rak disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 □Yes 2 □No 3 Suicide

be execute o of Vital funeral director, Hospital or Attending after death filled in by the To the Hospital within 24 hours a To the Funeral C completely

Physician/Medical Examiner à Be Completed Medical Certification: To

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinator mast be notified at once.

**Physician** 

/Medical

Examiner

Baltimore,

anda

25. Was case referred to medical

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 Homicide

(Check only

29a. Certifier

4mc

29c. License number

29d. Date signed (Month, Day, Year) 2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaniner must be notified at		19a. Informant's Name/Relation				ng Address (Stree					
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at any Injury or other traumatic event, the Medical Evaninar must be notified at any Injury or other traumatic event, the Medical Evaninar must be notified at any Injury or other traumatic event, the Medical Evaninar must be notified at		20a. Method of Disposition 1 → Burial 2 □ Cremation		3		sition (Name of matory or other pla	1				
artme artme ortani Injury		4 ☐ Donation 5 ☐ Other ( 21. Signature of Funeral Service		Sacr		art of Ma 2. Name and Addr					Maryland l Home,PA
Deparii Impol		PRILL OF	5								MD 21222
		23a. Part 1. Enter the disease,	or complications that cause st only one cause on each	ed the death.	·····					ĺ	Approximate Interval Between
Physician		Immediate Cause (Final	RF<	DIRA	TOP	ey fo	ALLIR	٤			Onset and Death
/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):	22-5	2 0	^			
LXammer	<u>+</u>	Sequentially list conditions,	b. Due to for a	NAF	ande of:	HRIE	Ky 6	158A	SE		
uted /	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	& CONG	ECT 1	1/2	HEAR	- FA	111187	2		
be executed ician and burial-transit		resulting in death) Last		s a conseque				120146			
eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical		CARD CARD	YON	1401	5 A THY	0				
ertific ding p	Mec	IF FEMALE:	000 16 1100 01400		/ /						
eath c attender	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1  Live birth 4  Pregnant	2 Fetal	death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date of delive Month	very Da <b>y Y</b> ear
at the de by the stached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		54II 5L	Other (specify) _					
res that signed b	by Pi	Part II. Other significant condi	tions contributing to death	but not resul	lting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?
w require been signature should b								. 1 🗆	Yes 2	□No 3□Pro	bably 4 Unknown
law re nas be	Completed							24a. Was	s an opsy	prior to o	opsy findings available ompletion of cause of
: The cate h	S							perl 1 □ Yes	ormed?	death?	2 <b>0</b> 0
siclan certifi rector	Be	25. Was case referred to medic examiner?	Hospital:			Ot	her:	eath (Check only			
Phys er this	7:10	1 Yes 2 No 27. Manner of Death	1 ∐ Inpa	iurv	ER/Outpatie 28b. Time o	nt 3 🗆 DOA	4 Nursing	Home 5 ☐ Res 28d. Describe		6 ☐ Other (Spec	ify)
ath. :: Afte	Certification:	1 Natural 5 □ Pend	/Adamsh C	Day, Year)	Injury		rḱ? ]Yes 2.∐No			,	
er degreector	tific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be 28e. Place of Ir building.	njury - At hor	me, farm, st	reet, factory, office		28f. Location	(Street ar	nd Number or Rui	ral Route Number,
ital or rra Dii											•
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical		ring Physician: To the bes al Examiner: On the basis and manner s	of examinat							
Vithi To the	Ž	29b. Signature and title of certif	ier	01	1 1.	29c. Licen	se number	2	29d. Da	ite signed (Month	, Day, Year)
		SUM	vecc 10	Ole 1	MD	1 22	21/88	5	1-	27-0	9
b		30. Name and address of person	on who completed cause of	death (Item	28a) (Type,	1B VIA	1-Plan	e D/1	, . A.	all Mar	21772
	ate	31. Date filed (Mortin, Day, Yea	67	trars Signat	ure	yur we	E · WC	- yu	100	W. Toll	1-1-11
Regist	rar	FEB 0 9	2009 Dehru	u p	1. lo	evel					
OHMH 17 Rev 1/	2001		,	/	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02677 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Harvey Ryon Coleman 3, 9:16 A.M February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore 8. Date of Birth (Month, Day, Year 8/24/1927 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days î⁄Qi⁄M 2□ F Months Hours Washington, D.C. 577-34-8357 81 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exemiter must be notified at Director Maryland Baltimore 1 ☐ Yes 2 ☐ No Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States 12101 Tullamore Court Unit 403 21093 of America Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? t⊕Yes 2 No If Yes, Give Year or Dates: Black, White, etc. ٥, 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Developer Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Burrell H. Coleman Eleanor Ryon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Health ; Mrs. Charmie M. Coleman/ wife 12101 Tullamore Court Unit 403 Timonium, Maryland Department of Heal Important: If Item 2 any Injury or other once. other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20c. Location - City or Town, State 20a. Method of Disposition February Pages 1 1 ☐ Burial 🎉 Cremation 3 ☐ Removal from State 4, 2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u> Chapel- Bel Air</u> 21. Signature of Funeral Service License Péacerul Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, MAryland 21093 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 4 Cars /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) certificate be Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant requires that the death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page perform certificate Vital 2 XNo 2 No 1 □Yes 1 ☐Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) Residence Other (Specify) WOSP ( 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To of funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the f after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L the Hospital † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature

1041

State Registrar

31. Date filed (Month, Day, Year)

FEB 0 3 2009

DHMH 17 Rev 1/2001

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N. Charin ST

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

09-00713

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Clayborne		Stat 1- For State Registrar	te of Maryland /	Department Certificate		d Mental H	ygiene Reg. l	No. 200	19 0267		
Physicia al Exami	an/	Decedent's Name (First, Middle,L  Joyce A. Claybo					2. Date of Death Month Da January 24,	ay Year	3. Time of Death 5 7 0800 hrs		
		4a. Facility Name (if not institution,	give street and number)		, ,	Location of Death		4c. County of Death			
Eumanal		Maryland General Hospi  5. Social Security Number 6.		(în yrs. last birthday)	Baltimore  If Under 1 Yea	ar If Under 24Hrs	. 8. Date of Birth(	MM/DD/YYYY 9 Bir	thplace (State or Foreign		
Funeral Director			1 M 2 X F	EO	Months Day			C-0	vanitry) VA		
, any		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits		
ne Maryland or 28a-f show any fied at once.	tor	MD Baltimor	re	Woodlaw			T40-	0.5-1-100	1 X Yes 2 No		
72 hours after death with the Maryland n'anaturat", or items 23a or 28a-f sho al Examiner must be notified at once.	Director	10e. Streat and Number 1700 Stella Court			10f. Zip Code 2120	7	10g.	Citizen of What Cou USA	ntry?		
r death with the or items 23a must be noti	uneral	11. Marital Status  1 X Never Married 2 Married	ied 12. Was Decedent E Armed Forces? 1 Yes 2	X No	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto		White, etc.	ican Indian, Black,		
	by F	3 Widowed 4 Divorce  15. Decedent's Education (Specify	ced If Yes, Give Year or Dates:	1	Yes 2 No		work dono	Specify: ATT16	can American		
uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner	eted	Elementary/Secondary (0-12)	College (1-4 or 5-	during	g most of working life			DD. KILIO OI BUSINESS/	industry		
led within Hygiene. other tha the Medic	Completed	12th		CIA		40.14 11 1.14		ederal Gove	rnment		
be filed ental Hyg irked oth	Be C	17. Father's Name (First, Middle, La Judge Clayborne	ast)				(First, Middle, Mai	den Surname)			
12 should be fi th and Mental 127 is marked umatic event,	ToE	19a. Informant's Name/Relationship	(Type, Print )		- ,	et and Number or I	Rural Route Numbe	r, City or Town, State	e, Zip Code)		
and 2 s erith ar tem 27 traums		Georgia Clayborne  20a. Method of Disposition			Edmondson Ar			0c. Location - City or	Town, State		
ages   ant of H nt: If is			3 Removal from State		r other place)		-31-2009	Woodlawn, M	m		
permit Pages I and 2 should Department of Herl;h and Me Important: If item 27 is ma injury or other traumatic ev		4 Donation 5 Other Spec 21 Signature of Funeral Service Lice	-4		Name and Addres	s of Facility	ie Funeral		ш		
¥ ā ≛ .≅ ysician		23a. Part I. Enter the disease, or co	omplications that caused t	the death. Do not ent	38 N. Cilmo	r Stroot Ra	ltimoro MI	21217	Approximate Interval		
Medical		failure. List only one cause on Immediate Cause (Final disease			or and mode or dying				Between Onset and Death		
caminer		or condition resulting in death)	Due to (or as a consec	quence of):			-				
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		ism						
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):					-		
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te be execut ysician and burial - tra	ledical	UNPENDED  IF FEMALE:	AMENDED		. 8000 1,0	., 05 11		22d Data of deliver			
aw requires that the death certificat has been signed by the attending ph 2 should be detached for use as the	Physician/IV	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Extopic pregnancy								
death certificat ne attending ph d for use as the	ysici	1 Yes 2 No 9 Unkno	own g Unknown	time of death 5	Other (Specify)						
hat the ed by the letached		Part II. Other significant condition						cco use contribute to			
quires t en sign uld be o	Completed by	Hypertensive Cardiova	scular Disease; Dia	abetes Mellitus;	End-Stage Rer	ial Failure	1 Yes		bably 4 Unknown utopsy findings available		
	mple						autopsy performe	prior to death?	completion of cause of		
ysician: The his certificate director, page		25. Was case referred to medical	Т		26.Plac	e of Death (Check	only one)	VNo 1 Y	es 2 No		
hysicis r this ce al direc	To Be	examiner?  1  Yes 2 No		nt 2 🗸 ER/Outpat				esidence 6 Othe	er:		
ending Phy ath. rr: After the he funeral		27. Manner of Death  1 Natural 5 Pendin		ry 28b. Time		ury at Work? Yes 2 No	28d. Describe how	w injury occurred			
Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director,	Certification:	2 Accident Investig 3 Suicide 6 Could r	not be 28e. Place of Inju	ury - At home, farm, s	street, factory, office	building, etc.	28f. Location (Street or Town, State		ural Route Number, City		
To the Hospital or Attend within 24 hours after death.  To the Funeral Director: completely filled in by the i	Medical Ce		sician: To the best of my iner:On the basis of exam								
To t To t	Med	29b. Signature and title of certifier	and manner stated.			se number		29d. Date signed (Mo			
		Med a	~	> 1/2)	0.0	.M.E.		February 3, 200	9		
10		30. Name and address of person will Russell Alexander MD.	ho completed cause of de Assistant Medica	, ,	11 Penn Stree	, Baltimore, M	ID 21201				
		31. Date filed (Month, Day, Year)	200 Decistors								
St Regist	tate trar	FFR 0.3.20	/	's Signature	Kal		n	CME			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Betty Jane Cotter 2, 10:00 A M 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center for Hospice Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Pennsylvania 8. Date of Birth (Month, Day, Year) 02/09/1930 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 205-22-2639 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2XXIIIo Director Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 1945 Sue Creek Drive 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2XXXVo Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 File Clerk Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk. Ida Mae Boyle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5973 Elk Forest Court, Elkridge, Maryland 21075 Thomas Cotter (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 02/04/2009 Saint Stanislaus Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part1. Firter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm vate Cause (Final **Physician** COMPLICATIONS Mars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any localing to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician a Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed' After this certificate funeral director, pag-1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSPLO 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 6701 IV. Charles

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Year)"

er's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death A M Flovd Dale Chenoweth 30, 2009 9:20 Ja**n.** 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Genesis Brightwood Lutherville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) WEST 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours **№** M 2□ F 217-20-6289 82 Virginia May 29, 1926 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Carroll Eldersburg Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6111 Flemish Blue Court 21784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 (Ayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Mail Clerk U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lola Pearl McDaniel Flovd Chenoweth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Chenoweth / Son 6111 Flemish Blue Court, Eldersburg, MD 20b. Place of Disposition (Name of commetery, crematory or other place) Memorial Gardens 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-03-09 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, Inc. of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA 1ca disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes € No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury

Examiner attending physician and of for use as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, signed by the a this certificate has al director, page 2 or Attending Physician: After this certification

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show dic-l Examiner must be notified at

other traumatic event, the Medic-4

than

12 should be filed w h and Mental Hygie 7 Is marked other tl

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun

**Physician** 

/Medical

Director

Funeral

þ

Completed

Be

Examine

Physician/Medical

Completed by

Be

Medical Certification: To

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: Completely filled in by the f To the Hospital

1 Natural 2 □ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of certifier Dre MD

D0053150

ddress of person who completed cause of death (Item 23a) (Type, Print)

Sentago Re Soute 110 2100 Commbre 110

21045

State Registrar

31. Date filed (Month, Day, Year) FEB 0 3 2009



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			_ For		State of	Marylan	d / Depa	artment of I	Health	and Me	ental Hy	giene	000	2 02	0
		•	1 - State Registrar			-	Ce	rtificate of	Deat	h		Reg. No.	ZUU	9 02	58
			1. Decedent's Name (F	irst, Middle, La	st)					2	. Date of De			3. Time of	f Death
	Physici		Vincent T	C1-	T					F	Month ebruar	τ <b>σ</b> 1	2009	2:15	Ам
-4,	/Medio Examin		Vincent J 4a. Facility Name (If no	ot institution, giv	an, Jr. e street and numb	er)		4b. City, Town, o	or Locatio		COI GGI		County of Dea		
ادر	LAGIIII	ici	Stella Ma	ris Hos	nice	,		Timon	i um				Do1	timore	
	Funeral	14	5. Social Security Num	ber 6. S	ex 7.	Age (In yrs. I	last birthday)	If Under 1 Year	If Und	er 24 Hrs. 8	B. Date of Bir	th Your	9. Bi	rthplace (State	or Foreign
	Director		220-30-52	22   1	MM 2□F	74	Yrs.	Months Days	Hours	s Min.	(Month, Da June_2	6.1	934	o <i>untry)</i> Marylan	nd
	p		Usual Residence of De		•										
	urylar Show	_		b. County		10c. City	y, Town or Lo	cation						10d. Inside C	•
	Ba-f	cto	MD	Baltimo	re	(	Cockey	sville							2 [ <b>X</b> No
	ith th	Director	10e. Street and Number					10f. Zip Code				10g. Cit	izen of What C	ountry?	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show w.M.e.dical Evarrinet: just by routified at	Funeral	1106 Dul	aney Ga					21030				U.S.		
	er de	une	11. Marital Status		12. Was Decede Armed Force	es?	S.   13.	Was Decedent of I If Yes, specify Cub	Hispanic ( ban, Mexic	Origin? (Spec can, Puerto Ri	ify Yes or No can, etc.)	-	<ol><li>Race - Am Black, Whi</li></ol>		
36	s afte	by F	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 □Yes 2 If Yes, Give			1 □Yes 21X No	Speci	ify:			Specify: T.T.	nite	
Ö	hour tural	ed k		i. Decedent's Ed	Year or Date	55.	16a Dece	dent's Usual Occu	ination		-	16h K	ind of Business		
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an	d be ental ced c	To Be	Vincent	T Cross	han Cu				m		0				
Maryland 21215-0036	d 2 should be fi th and Mental I 7 is marked ot traumatic evel	F	19a. Informant's Name				19b. Maili	ng Address (Stree		neresa nber or Rural			or Town, State.	Zip Code)	
		J. J.	Katherine	Crocha	n / Wife			•							020
Baltimore,	- I 5 =	1 3	20a. Method of Dispos		II / WITE	20b. P	Place of Dispo	Dulaney sition (Name of	Jale	Da	e, Coc	20c. Li	ocation - City o	MD 210 r Town, State	J <b>3</b> U
OL.	e = ;		1 [x] Burial 2 □ 0 4 □ Donation 5 l			ate Du		matory or other pla Valley Gardens	ace)	02-04				, Maryla	and
量			21. Signature		-	I (MA)	norial	Gardens  2. Name and Addr	ess of Fa	i cility D <sub>1.1</sub>	ck Tow			l Home,	
Ba	permit. Departr Importa any inju		46	1 min	W.	-11.	)	1050 Yo						21204	IIIC.
			23a. Part 1. Enter the	disease, or com	plications that cau	ised the death	h. Do not en						yrand	Approxima	ite
		25 5	shock, or heart for Immediate Cause (Fir	ailure. List only	one cause on eac	h line.		<b>-,</b>				,		Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	-	cl.	CANCE									
Carlo Par	Examiner				Due to (or	as a consequ	uence or):								
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	nsit A	Examiner	Sequentially list condit if any, leading to imme Cause (Disease or inju	ng diang											
_6	be executed ician and burial-transit	xal	that initiated events ' resulting in death) Las	100	C. Due to (or	as a consequ	uence of):								
760,				- L	al										
687	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the this control of the c	Physician/Medical			_ u							-			
Вох	eath certific attending p for use as	N N	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outco								23d. Date of d	eliverv	
ă	death a atte	cia	in the past 12 mg	onths?		th 2□Feta nt at time of c		☐ Ectopic pregnan☐ Other <i>(sp</i> ec <i>ify)</i> _	ncy				Month	Day	Year
0	t the de by the tached	ysi	9 Unknown		9 Unknow	vn									
σ.	that hed b		Part II. Other significa	nt conditions	contributing to dea	th but not res	ulting in the u	nderlying cause gi	iven in Pa	ırt I.	23e. Did 1	tobacco	use contribute	to the cause of	death?
ds	uires t 1 sign 1d be	d by									1 🗆	Yes 2	□ No 3□ i	Probably 4X	Unknown
Records,	w requir been s should	Completed									24a. Was	an	24h Were	autopsy findings	available
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Vital	sician: The la certificate ha irector, page 2		05 18/22 222 225		1						1 Tyes	2 <b>X</b> No	1 ☐ Ye	ıs 2□No	
Ξ	sicia cert irecto	Be o	25. Was case referred examiner?		Hospital:		ED/O	Ot Ot	thar	ace of Death			- TT-0-1	HOCK	TOP
of	Phys r this ral dii	<u>2</u>	1 Yes 2 No 27. Manner of Death	<u></u>	28a. Date of	Datient 2	28b. Time of	•			e 5 ∐ Resi 3d. Describe			ecify) HOSP	TCE
on	or Attending I after death. Director: After in by the funer	ţio	1 X Natural	5 ☐ Pending investigatio	(Month	Day, Year)	Injury	Wo	ork? ⊒Yes 2	_ i			.,		
S	Attendi er death. ector: A by the fu	fica		6 ☐ Could not b	e 290 Place o	f Injury - At ho	ome, farm, st	reet, factory, office			Bf. Location /	Street a	nd Number or I	Rural Route Nur	mher
Division	l or Att after d Direct d in by	Certification:	4  Homicide	determined	building	, etc. <i>(Specit</i>	fy)	,,			City or To	wn, State	e)		,
_	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier 1[	☐ Certifying Pi	hysician: To the b	est of my kno	wledge, dea	th occurred at the	time, date	e and place, a	nd due to the	e cause(s	s) and manner	as stated.	
	24 h	Medical	(Check only 2	☐ Medical Exa		sis of examina		nvestigation, in my							s)
	To the vithin To the compl	₩	29b. Signature and title		- TOHOL			29c. Licer	nse numbe	er		29d. Da	ate signed (Mor	nth, Day, Year)	
	FSFO		10	1 AM	1/10/1	0		1214	197	97	-	7	12/20	. 9	
	1		30. Name and address	S of person who	completed source	of death (Item	n 23a) /Tuna	Print) / 7/7	11	10			10/00	~/	
	9		JACKIE J						ጥተነ	MONTIN	MD 3	1002			
	Sta	ate	31. Date filed (Month,			gistrar's Signa		LLEY RD.	1.11	MONIUM	, rw Z	1033			
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 2<u>009</u> Month 2:45 P M 26 Leroy Colquitt, Jr. Januarv 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, Hours Days Months 1 ☐ M 2 ☐ F Pennsylvania May 9, 188-28-9021 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes XX No Marvland Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 21044 4956 Snowy Reach Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: B1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) 12 Physicist Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Etta Jane Fuller Leroy Colquitt, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4956 Snowy Reach, Columbia, MAryland 21044 Wanda Colquitt - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 1/31/2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Gary L. Kaufman Funeral Home, I 7250 Washington, Blvd. Elkridge, Maryland 21075 21. Signature of Funeral Service Licensee 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OLON Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): delivery Day Year te to the cause of death?

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Be Completed

Certification: To

Medical

29a. Certifier

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

and burial-trar physician for use detached page 2

after death. filled in by the within 24 hours a

the Hospital or Attending Physician; The law requires that the death certificate be execut

Division of Vital Records, P.O. Box 68760,

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed?  1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2: No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hon	ne 5 Residence Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	on (Month, Day, Year) Injury Work?  M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

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completely

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

Sheara Cox	Please Type or Print in Black Indelible I State of Maryland / Department o			9 02683
Sileara Gox	1- For State Certificate o	_	Reg. No.	,, 0200,
Physician/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month Day Year	3. Time of Death 0921 hrs
	4a. Facility Name (if not institution, give street and number) 3036 Fleetwood Avenue	4b. City, Town, or Location of Death Baltimore	January 26, 2009  4c. County of De	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	1 150	Birthplace (State or reign
Director	2 3-60-6049   1   M 2   F   54   Yrs   Usual Residence of Decedent		10.7.1954	Country)
w any	10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits
Ra-f sho	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tent 27 is marked other than "natural", or items 23a or 28a-f show transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3036 Fleetwood Ave	21214	U.S.	A
leath wit	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	as Decedent of Hispanic Origin? (Spi Yes, specify Cuban, Mexican, Puerto I		merican Indian, Black, c.
s after d		Yes 2 No specify:	Specify:	Black
136  lin 72 hours afte e. than "natural"; edica Examiner	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retin		ss/industry
5-0036 He within 72 hours aft Hygiene. I other than "natural" the Medical Examine.	17. Father's Name (First, Middle, Last)	Clerk 18.Mother's Name	(First, Middle, Maiden Surname)	of Manyland
21215-00 uld be filed wit Mental Hygien marked other c event, the M	Harvey L. Williams Sr.	Wille	a Mae Probi	nson
nore, MD 21215-0036  ages I and 2 should be filed within 72  nt of Health and Mental Hygiene  t: If item 27 is marked other than other transmatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print)  Tisheova F. Wilson 548	ng Address (Street and Number or R	0 10 11.	tate, Zip Code)
7		osition (Name of cemetery,	Date 20c. Location - City	
Baltimore, permit. Pages I ar Department of the Important: If ite injury or other tr	4 Donation 5 Other Specify  21. Signature of Funeral Service Licensee 22.	on Forest 2.	3.2009 Balt	imore MD
Depa Depa injin	Vaughon C. Dreene 4	905 York And Bu	Stimore MD	91313 SIM SELVICES
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.      Immediate Cause (Final disease a. Hypertensive Atherosclerotic Card		r respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Typertensive Atheroscierotic Card Due to (or as a consequence of):	- Ilovasculai Disease		
9	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):			
red nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		<del></del>	
executed an and al - transi	d. UNPENDED AMENDED			
			23d. Date of deli	very
Box 68760, e death certificate be the attending physic effor use as the bur hystellan/Med	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Figure 2 Figure 2 Figure 3	etal death 3 Ectopic pregnal Other (Specify)	ncy Month	Day Year
). Box 68760, the death certificate be by the attending physicicited for use as the burn Abus of Clan/Med	1 Yes 2 No 9 ✓ Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be as fine death.  In Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be deached for use as the burification: To Be Completed by Physicilan/Med			1 Yes 2 No 3	
ing Physician: The law requires the rectificate has been significate has been significate has been significate has been significate has been significated freedor, page 2 should be completed.				e autopsy findings available to completion of cause of
I Rec i: The l lificate l or, page		26.Place of Death (Check of	1 Yes 2 ✔ No 1	Yes 2 No
f Vital Physician or this certinal director To Re	examiner? Hospital:	Other:	g Home 5 Residence 6 O	ther: Scene
on of adding P. the contract of the contract o	27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of	Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division o spiral or Attending tours after death neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre	eet, factory, office building, etc.	28f. Location (Street and Number of or Town, State)	r Rural Route Number, City
Divisior  Nopital or Attend 4 hours after death funeral Director: ely filled in by the t	4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu	urred at the time, date and place, and		etated
Division of Vital Records, P.O. Box 68760, To the Hospitan or Attending Physician: The law requires that the death certificate be within -4 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the buring addition. To Ba Completed by Physician/Median	(Check only 2 Medical Examiner: On the basis of my knowledge, death occurrence)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred at	t the time, date and place, and due t	o the cause(s)
		29c. License number O.C.M.E.	29d. Date signed (January 27, 2	
13	30. Name and address of person who completed cause of death (Item 23a)	MC		
0CME Stat	31. Date filed (Month, Day Year) 32. Registrar's Signature	11 Penn Street, Baltimore, M	D 21201	
Registra	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	led		
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DHMH 17 Rev 1/2001 OCME 2006 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** 1:10PM ovination 01 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kville Montaomery Under 1 Year | If Under 24 Hrs. place (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 216-54-398 Usual Residence of Decedent **Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Mont Director 10g. Citizen of What Country? rose meadow USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Blac 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Items once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) re Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be ovination Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, C 1088 emeadow Ct. G 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heard failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or 📥 a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecutance of: Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit 4 ell abeles Due to (or as a consequence of) Box 68760, tage Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No as been signed by the 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 3 No After this of funeral direction ၀ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koualchou DOB 63748 Jocelyne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 3 2009 Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 02685 2009 Tayon Crawford Certificate of Death 1- For State Reg. No 3. Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1430 hrs January 25, 2009 Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Havre de Grace Harford Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours 10-08-1982 Director 3108 1 V M Yrs nce of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a, State 10h County Yes 2 No items 23a or 28a-f show ust be notified at once with the Marykand Director 10g. Citizen of What Country? 10f. Zip Code *2*(00) 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Married Yes 0 2 No specify: Yes If Yes, Give Year Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 t; If item 27 is marked other than other transmatic event, the Medical 21215-0036 and Mental Hygiene 18 Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Kegina or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Num 8 Baltimore, other place) Removal from State Cremation 3 ij0 Other Specify 22. Name and Address of Facili Vaughn ature of Funeral Serv Baltimore Approximate Interval ort I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** ailure. List only one cause on each line Death Mardical a. Complications of gunshot wounds Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a,27,28a-f,perME,g889 3/26/09 TT Physician/Medical X UNPENDED tending physician a use as the burial -23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy Year Dav Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown ned by the a detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 V Unknown þ ۵. Completed 24b. Were autopsy findings available Records, 24a. Was an autopsy prior to completion of cause of performed? death? certificate has 2 No 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other 4 Residence 6 examiner Hospital: 1 / Inpatient 2 Nursing Home 5 ER/Outpatient 3 this ပ 1 ✓ Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: subject shot Yes 2 X No Natural Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f Fd 4:45 /12/2005 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/00 Blk. St. Lo Drive 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State). 4. Baltimore, local street MDdetermined 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 28, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD Registrar's Signatur State

Registra

**ORIGINAL** 

**OCME** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02686 State of Maryland / Department of Health and Mental Hygieney For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year :40AM millie 2009 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner 16e If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours | Min. Month, Day, etimore mmil 5. Social Security Number 7. Age (In yrs. last birthday).

88 Yrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** -22-25 1 □ M 2 🛂 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director TONS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1502 rederic 2122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🕅 No Ś Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car 1A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be eese boro Calie Hillard ပ္ 19a. Informant's Name/Relationship, (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -daughle 325 melvin Ave Apt A nise atonsville 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State mem. F 4 ☐ Donation / ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of meral Service Licens 23a. Part J. Er er ne disease, or complications that caused the shock, or eart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between set and Death Immediate Car se (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery signed by the atter 3 Ectopic pregnancy Month Day Year 5 Other (specify) No □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 AND 2 1No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Marran of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending I Director: And in by the f investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Olga C. Chiavacci 6:55 P.M January 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Lutheran Village Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 195-10-2738 Director 98 <u>June 18, 1910 Pennsylvania</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifiled at 1 ☐ Yes 2 1 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Taunton Avenue 21228 Completed by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wind Health and Mental Hygier item 27 is marked other the other traumatic event, the Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental 8 Emil Pagliari Mary Aetta Gelimine ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and :
Department of Health
Important: If item 27
any Injury or other tra 112 Taunton Avenue; Catonsville, MD 21228 Walter P. Chiavacci Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 2/3/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21206 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee 112 Hauker )an 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** reluming disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BU Sequentially list conditions, if any leading trimmed at cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner physician and the burial-trans emenha that initiated events resulting in death) Last Due to (or as a consequence of): physician attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 month Month Day Year 5 Other (specify) signed by the a d be detached for 1 Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed this certificate 1 □Yes 2 1 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 NIN Certification; To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 2 🗆 No 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title

filed within 72 hours after death with the Maryland

Maryland 21215-0036

3altimore,

requires that the death certificate be executed

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Records,

Vital

of

Division

Chiavacci

State

Registrar

aman

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Westminity MD 21151

			For State Registrar	State of Marylan		artment of <i>rtificate o</i>		-	giene Reg. No. 0 9	02688
	Dhusisi		1. Decedent's Name (First, Middle, Last,				-	2. Date of De	Dav Year	3. Time of Death
	Physicia /Medic		Mary Cascio					Janua	ry 29200	
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Dea	ال ال	of County of Dea	hmore.
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)	If Under 1 Year			th 9. Bir	thplace (State or Foreign
	Director		216-20-5409	M 2⊠F 80	Yrs.	Months Day	rs Hours Mir	May 28	, 1928 Mar	yland
	and W		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	o	Maryland Baltimo	re Ca	atonsv	ille				1 ☐ Yes 2 ☒ No
	h the	Director	10e. Street and Number			10f. Zip Code	,		10g. Citizen of What C	ountry?
	23e c	raiD	711 Maiden Choice	e Lane			21228		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hylgiene. Department of Heatin and Mental Hylgiene. Department: if Itam 27 is marked othar than "netural", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examiner must be notified at any injury or other treumatic event, the Madical Examiner must be notified at Quice.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of If Yes, specify Control of Yes 2⊠ N	of Hispanic Origin? ( uban, Mexican, Pue Blo Specify:	Specify Yes or No orto Rican, etc.)		
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and	d be f ental h ced of	To Be	Pietro Liberto					Rose Bro		
ary	shou and M s mar	-	19a. Informant's Name/Relationship (T)						er, City or Town, State,	
Σ,	and 2 ealth m 27 I		Anthony Cascio	Son			v Drive;		lle, MD 212	
Baltimore, Maryland 21215-0036	ges 1 it of H if Ital		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, cre	osition (Name of matory or other p	0.10	Date /2000	20c. Location · City or	
Ħ	artmer artmer prtant injury		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>			w Mem. I	alk	/2009 erling As	Sykesvill shton Schwa	e, MD 21228 b Witzke
Ва	Depi Impo	2 3	A. A. The	M014	190 F	uneral I	Home of C	atonsvil	le, Inc. tonsville,	MD 21228
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the deat	h. Do not en	ter the mode of o	lying, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		100				years
	Examiner	<u>.</u>	Sequentially list conditions,	b	mence of).					·
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oʻ	execu an and rial-tra	Еха	resulting in death) Last	Due to (or as a conseq	uence of):					
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.O. Box	the thed	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 31	□Ectopic pregna □ Other <i>(specify)</i>			23d. Date of de Month	Day Year
<u>α</u>	res that the signed by be detaction	by Pr	Part II. Other significant conditions co	ntributing to death but not res	ulting in the	underlying cause	given in Part I.	23e. Did 1	tobacco use contribute t	to the cause of death?
orde	w require been sig should b	ted t						. 10	Yes 2 DNo 3 DF	robably 4 Unknown
Division of Vital Records,	: The law r cate has be : page 2 sh	Completed						24a. Was auto perfo 1 Yes	psy prior to ormed? death?	utopsy findings available completion of cause of s 2 No
Z.	sician certifi irector	Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	IED/O-++	-1 20 004	Other 1	eath (Check only		
ō	Physer this eral d	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time	of 28c. Ir	Hury at	-	idence 6 Other (Spenior occurred	эспу)
ion	Attanding death. ctor: Aft y the fun	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIII, Day Tear)	Injury		Vork? □Yes 2□No			
Divis	or / fter Dira in b	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, s	treet, factory, offi	C8		Street and Number or F wn, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my knowner: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at the	e time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To tha within 2 To the complex	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date signed (Mor	nth, Day, Year)
	->-0		1 Who Sto	am. en		D	4700	9	Tahuas	292009
	n		30. Name and address of person who c	ompleted cause of death (Iter	п 23a) (Туре	, Print)	-	1	D II	29,2009 eMD21228
	)		31. Date filed (Month) Dev Year)	32. Raising Sign	ature	uden	noice	chane	15altimos	2 MD 21228
	Sta Regista		FER (199)		1 1	barker		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:00P<sup>M</sup> 28,2009 Chawlitko Celia Μ. January /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Rineholt Assisted Living Rising Sun Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F California May6,1917 Director 550-16-9044 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 Is marked other than "natural" or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Cecil 1 ☐ Yes & No Md. Port Deposit Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21904 19 Devon Drive U.S.A. Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 12 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural" or Iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Home Maker <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Lomielle Paul Duenas ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Betty Maltese (Daughter) 19 Devon Drive Port Deposit, Md. 21904 of Health injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5 KlOthe Esaction bment St.Stanislaus Cem2-2-2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitikaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications, has caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest, shock, or heart failure. List only one car set or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 ☐ Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 20 No 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an page 2 autopsy Physician: 25. Was case referred to medical examiner? fur eral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death A er or Attending Injury 1 Natural 5 Pending 1 ∏Yes 2 ∏No death. 2 ☐ Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled i⊢ by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

4 hours after death. Funeral Director: A within 24 hours a

To the Funeral I

completely filled

> State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month; Day, Year)

MI

29c. License number

29d. Dale signed (Mjonth, Day, Year)

and manner stated.

32. Registrar's Sign

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 2009

		FOF	Department of Health and	Mental Hygie	ne
_	_	State Registrar	Certificate of Death	Reg.	No.2009 02690
Physician	n	1. Decedent's Name (First, Middle, Jast)		2. Date of Death Month	Day Year 3. Time of Death
/Medica		lyrone buncan		January	
Examine	r	ta. Facility Name (If not institution, give street and number)  Franklin Silvane Hospital	4b. City, Town, or Location of Death	n Y	4c. County of Death  Roll + index 100
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year   If Under 24 Hrs.		9. Birthplace (State or Foreign
Director		217-86-1456 15M 2□F 58	Yrs. Months Days Hours Min.	Jen 7	951 Har, land
p >	1	Usual Residence of Decedent         10c. City, Town           10a. State         10b. County         10c. City, Town	or Location		10d. Inside City Limits
laryla shov	- 1	1. 1 13 11 01			1 ☐ Yes 2 ☐ Mó
the M	ect	Md Dalto. Park	10f. Zip Code	10a	. Citizen of What Country?
3a or the r	Funeral Director	7801 Oak Ave	101. 219 0000	109	H.S.A.
death death	Dera	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	Specity Yes or No-	14. Race - American Indian,
after or ite	2	Armed Forces?  1 Married 2 Married 1 □ Yes 2 Ms No If Yes, Give	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 M No Specify:	to rican, etc.)	Black, White, etc.
21215-0036 d within 72 hours af gjene. The matural", or the Medical Exam	g p	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Mace
15-1 17-1 17-1 10-1 10-1 10-1 10-1 10-1 10	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	rking	b. Kind of Business/Industry
withigh	티	Elementary/Secondary (0-12) College (1-4or 5+)	Disabled		Discipled
ind 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Se Re	17. Father's Name (First, Middle, Last)		me (First, Middle, Mai	iden Surname)
Irylan should be and Menta marked imatic ev	9	James Duncan	Mary	R. In	nes
Maryland Maryland d 2 should be file th and Mental Hy zr is marked oth traumatic event		19a. Informant's Name/Relationship (Type. Print)	. Mailing Address (Street and Number or Ri	ural Route Number, C	
and and and and and are tr		Mary R. Imes mother 7	51 W. Saratuga	ot. upt 30	7 Bald. Hd 21201
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of cemete.  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of ry, crematory or other place)	Date 20	c. Location - City or Town, State
timen timen trant:	-	4 □ Donation 5 □ Other (Specify)   King,		6,2009 1	Tal ho bed
Balti permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee	Carlby C. Dougla	is Funer	al Service P.A. B. Add. 21217
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dving, such as cardia		
Rhysiology		Λ .	_	,,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  AN OXIC ENC Due to (or as a consequence	SPHALO PATHY		
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P. F.	ner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury	of):		
and trans	Examiner	that initiated events	-0.		
		Due to (or as a consequence	or):		
38760 icate be e physician s the buris	dical	d			
Box 6: leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery
Box death cert	ciar	in the past 12 months?  1 Ves. 2 No.  1 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
t the oby the archee	hys	9 ☐ Unknown 9 ☐ Unknown			
cords, P.O. w requires that the de been signed by the signoid be detached	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
ould to				1 ☐ Yes	2 No 3 Probably 4 donknown
Reco	ble			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The	Completed			perform <i>e</i>	d? death? ]No 1 ☐ Yes 2 ☑ No
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On Or ding Phys	<u>۹</u>	The s 2 No Thin patient 2 ER/OU		Home 5 ☐ Residence	ce 6 Other (Specify)
On ding h. After fune	힐		Time of injury M	20d. Describe now	ngary occurred
Atten r deat	lica	3 Suicide 6 Could not be 28e. Place of injury - At home, fa	rm, street, factory, office	28f. Location (Street	et and Number or Rural Route Number,
Div al or saffer of in t	ert	4 Homicide determined building, etc. (Specify)		City or Town, S	state)
Division or To the Hospital or Attending Phenin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification:	29a. Certifier  (Check only  2	e, death occurred at the time, date and place	e, and due to the cau	se(s) and manner as stated.
the H hin 24 the F	edic	one) and manner stated.			
To To com	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
		- Pany Merpy	DOSCOSSO	15	BRUARY 1, 2009 SVILLE, MA-21030
4		30. Name and address of person who completed cause of death (Item 23a)  PANICAT LHETERAL 26. 123	(Type, Print) N Mill GARTH	CUCKEN	CVILE, MA-2102
State	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	מו במודף שיייו ע	COCKEY	2 - 11.2 - 470
Registra		EED 0 2 2000 A	backer		

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			Plea  L_State	se Type or Prir State of Ma	aryland / D	<b>c Indelible Ink</b> Department of F Certificate of	Health and N	/lental Hy	giene	. 02601
	Physicia	n	Registrar  1. Decedent's Name (First, Middle)			Certificate of	Dealli	2. Date of De		3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution	n B. Dougl		4b. City, Town, o	r Location of Death		4c. County of De	
1	Funeral		5. Social Security Number 230-01-7201		e (In yrs. last birt		If Under 24 Hrs. Hours Min.		th 9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					00/20/	1920   VI	10d. Inside City Limits
	-f show	to	PA 10b. County	ork	New F	reedom				1 □Yes 2 X No
1	or 28a	Direc	10e. Street and Number	a) C		10f. Zip Code 1734	10		10g. Citizen of What U.S.A.	Country?
2	permit. Pages 1 and 2 should be lied within 72 hours arier death with the waryantu Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examination must be multified at once.	/ Funeral Director	17493 South  11. Marital Status  1 Never Married 2 Mar	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of Hif Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		
Z 13-00:	in 72 nours n "natural", Notical Exa	Completed by	(Specify only highe	Year or Dates:- nt's Education set grade completed) College (1-4or s	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of worl	king	16b. Kind of Busines	ss/Industry
717 D	Hygiene Hygiene rther tha		Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle		o+)	Foreman	18. Mother's Nam	ne (First, Middle	, Maiden Surname)	
yland	Mental Mental arked o	To Be	Paul Douglas	5				Barnes		
Mar	d 2 sho th and 7 Is me traume		19a. Informant's Name/Relation: Robert Dougl			Mailing Address (Street 493 South				e, Zip Code) 17349 .om • PA
ore,	es 1 an of Heal f item 2 r other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation			Disposition (Name of ry, crematory or other pla		Date 05/09	20c. Location - City	
Baitimor	ermit. Pag epartment nportant: I ny injury c nce.		4 Donation 5 Other (	Specify)	Veter	evans Cemete	ery : meral <sup>y</sup> Ch	apel 8	 ? Cremati	on Services
			23a. ' ar 1. Enter the disease, c sh.ck, or heart failure. Lis Immediate Cause (Final	t only one cause on each I	ine.	not enter the mode of dy	ing, such as cardiad		ville, MD arrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		dise so or condition resulting in death)	a	a consequence	ULAR ACCII	/E.N 1			YEARS
	ed sit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		a sonsequence	RATORY ARI	DECT			45 MIN
ಶ .	te be executed sician and e burial-transit		that initiated events resulting in death) Last	C	s a consequence		S Base Seed E			Chart II do 4 %
O. Box 687	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	e of pregnancy 2□ Fetal death at time of death	n 3 ☐ Ectopic pregnan 5 ☐ Other (specify)			23d. Date of Month	delivery Day Year
ds, P.	uires that t n signed by Id be detad	δ	Part II. Other significant condit	iions contributing to death	but not resulting i	n the underlying cause gi	iven in Part I.		+1	e to the cause of death?  Probably 4 Unknown
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<u> </u>	ysiciar is certif directol	o Be	25. Was case referred to medic examiner?  1  Yes 2 No	al Hospital: 1 ☐ Inpat	tient 2 ER/O	utpatient 3 DOA Ot	26. Place of Dea ther: 4 ☐ Nursing H		one) sidence 6 □Other (8	Specify)
ion of	To the Hospital or Attending Physician: within 42 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director director directors directo	Certification: To	D L T I CONTROLLE	tigation	jury 28b. ay, Year)		ury at ork? ⊒Yes 2 □ No	28d. Describe	how injury occurred	
Division	tal or Atters as after de al Directo ed in by the	Certific	4 Hornicide	mined 20e. Place of it building, e		arm, street, factory, office		City or To	(Street and Number o own, State)	
	e Hospi 124 hour e Funer letely fill	edical	29a. Certifier 1 Certify (Check only one) 1 Medica	ring Physician: To the bes al Examiner: On the basis and manner s	of examination a	e, death occurred at the nd/or investigation, in my	time, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s) and manne e, date and place, and	er as stated. due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certif	ier			nse number		29d. Date signed (M	onth, Day, Year)
	1		30. Name and address of perso	n who completed cause of			9215		1/30/	
	341		GAIL P. CUN	ININGHAM. M	i.D. 7	601 OSLER	DRIVE	TOWSOL	V, MARYLAN	D 21204
	Sta Regist		31. Date filed (Month, Day, Yea	32.00%	trar's Signature	Jakel				

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 8:00 February Howard James Dutrow 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a 1241 S. Grantley Street Baltimore 8. Date of Birth (Month, Day, June 24, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Days Hours Year Months 1**X** M 2□ F 1919 Virginia 229-34-7001 89 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director Maryland n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1241 S. Grantley Street 21229 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Yes, Give 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Auto Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie C. Danner Harry M. Dutrow ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1241 S. Grantley Street, Baltimore, Maryland 21229 Wife Maria Antonia Dutrow / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/5/09 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Figratu of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Days resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1□ Yes Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day, Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi physician the burial Division of Vital Records, P.O. Box 68760, attending p for use as 1 signed by the a s certificate has t irector, page 2 s this 24 hours after death.

Funeral Director: After thiletely filled in by the funeral

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ir Items 23a or 28a-f shov timer roust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any Injury or other traumatic event, the Middel Eva of met once.

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

the Maryland

within 2 To the

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0

29b. Signature and tipe of certific

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DS1018 February 3,

Ave. Battimore, MD 21227

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 02693 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 6:22 January C. DiPaula, Sr. James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crownsville 1249 Algonquin Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 √ M 2 □ F 90 Yrs May 29, 1918 Maryland 219-05-7664 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Exacitors must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** Baltimore Towson Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 1 Smeton Place #600 or Items 23a 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Be Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) General Wiping Cloth Co. Partner & Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental F tem 27 Is marked otl Rose Maggio Charles Ciro DiPaula ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Smeton Place #600 Towson, Md. 21204 Mrs. Mary Patricia DiPaula/ Wife 20c. Location - City or Town, State tem 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-30-09 Towson, Md. Co.: Hilltop Service 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final suprabulbar **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Yea in the past 12 months? Month Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 🔽 Hospital or Attending Physician: 24 hours after death. Funeral Director After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital: 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HRISTINE LAFFERMAN 31. Date filed (Month, Day, Year)-Registrar

		1	For State Of M	, ,	ertificate of De			. No. 2 1 1 9	02694
	Physicia		1. Decedent's Name (First, Middle, Last)  Marie T. deGi	rouchy			2. Date of Death Month JANUARY	Day Year 29, 2009	. Time of Death 26 : 35AM
- Ta	/Medic Examin		Aa. Facility Name (If not institution, give street and number	)	4b. City, Town, or Loc			4c. County of Death	
and the	Funeral Director		Saint Joseph Medical  5. Social Security Number 6. Sex 10 M 2 1 F A	ge (In yrs. last birthda)  86 Yrs.			8. Date of Birth (Month, Day, Nov 2, 1		e (State or Foreign
	ט	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	Location			10d.	Inside City Limits
	a-fsho		MD Baltimore	Balo	dwin				1 □ Yes 2 <b>X</b> □ No
	with the	Funeral Director	10e. Street and Number 5603 Patterson Road		10f. Zip Code <b>210</b> ]	13	109	g. Citizen of What Country?	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evan has must be notified at or other traumatic event, the Medical Evan has must be notified at	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  1 ☐ Ves, Give Year or Dates	XΛο	3. Was Decedent of Hispa If Yes, specify Cuban, N 1 □Yes 2 • No S	anic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc.	
Baltimore, Maryland 21215-0036	within 72 hor iene. • than "natur h	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or	(Giv	cedent's Usual Occupatio ve kind of work done durii b. DO NOT use retired) Homemaker	on ng most of workin	99	6b. Kind of Business/Indust  Own home	ry
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rylaı	should be filed within and Mental Hygiene. s marked other than iumatic event, the Man	2	Joseph  19a. Informant's Name/Relationship (Type. Print)	Teefy	illing Address (Street and	Marie Number or Bura	I Route Number.	Harris City or Town, State, Zip Co	ode)
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imore	permit. Pages 1 a Department of He Important: If item any injury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	<sup>°</sup> St. Johi	position (Name of rematory or other place) n Cemetery	02/0	2/09	Hydes, MD	
Balt	permit Depart Import any in		21. Signature of Funeral Service Licensee Willia		1050 York F	Rd. Tows	on, MD	Funeral Hom 21204	
	Lificate be executed  Medical Examiner as the burial-fransit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	ine.    MONIG   as a consequence of):   as a consequence of):   as a consequence of):	enter the mode or dying, s	Sucr as Cardiac C	in tespiratory and	in Oi	oproximate terval Between nset and Death
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ls, P.	es that igned b be deta	þ	Part II. Other significant conditions contributing to death			in Part I.	23e. Did tob	acco use contribute to the o	cause of death?
cord	w requires t been signe should be	eted	CHRONIC OBSTRUCTIVE I	PULMONARY	DISEASE		24a. Was ar	24b. Were autopsy	y findings available
of Vital Records,	i: The lavicate has	Completed						death? No 1 ☐ Yes 2	letion of cause of
F Vit	ysiclan: T is certifica director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Inpa	atient 2 ER/Outpa	Othor		me 5 ☐ Reside	nce 6 ☐ Other (Specify)	
	ng (fte	tion: 1	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of I (Month,	njury 28b. Time Day, Year) Injur	ry Work?	at s 2 □ No	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	Z E //colddin	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Rural F , State)	loute Number,
	Hospital 24 hours 8 Funeral I	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the besidence on the past and manner and manner on the past and manner on the past and manner on the past and manner on the past of the past on the past on the past of the past on the past on the past of the past on the pa	s of examination and/o	eath occurred at the time or investigation, in my opin	e, date and place, nion, death occur	and due to the cared at the time, da	ause(s) and manner as stat ate and place, and due to th	ed. ne cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier  A. (7. Helory)		29c. License r	7695		od. Date signed (Month, Da January 20	y, Year) 7, 2009
	1.		30. Name and address of person who completed cause of						
	St	ate	31. Date filed (Month, Day, Year)  SER 0 3 2009		COSLER DR		OM <del>SO</del> M' µ	IARYLAND 21	27/4

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John Anthony Deems January 30, 9:20 $P^{M}$ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A FutureCare Canton Harbor Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 31, 1951 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 57 212-56-4871 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 U.S.A. 3643 Keswick Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married l ∐Yes 2**X** No If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doorman Harper House 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward M. Deems, Sr. Catherine Elizabeth Palmizano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19958 Dolores Troxel 23026 Prince George Drive, Lewes, Delaware 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Cathedral Cem. Feb 3,2009 Baltimore, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Juneral Service Licenses 3631 Falls Road, Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tastatic Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 No 23e. Did tobacco use contribute to the cause of death? Inknown 1 ☐ Yes 2 No 3 Probably 411631114 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) 1 Yes 2 Yo cify) 27. Manner of Sath

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

ö

Funeral

ģ

Completed

with the Maryland

death v

filed within 72 hours after

Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the M

permit. Pages 1 and Department of Healt, Important: If item 27 any injury or other t once.

Baltimore, Maryland 21215-0036

Examiner burial-tran attending physician for use as the buria Physician/Medical cate has been signed by the page 2 should be detached ģ Completed certificate Be Medical Certification: To 24 hours after death.

e Funeral Director: After the letely filled in by the funeral

1 Naturai 2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

31. Date filed (Month, Day, Y

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

9 L Unknown	
t II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part
$\Delta \cdot \Delta \circ \Delta \circ \Delta \circ a$	

)	1 ☐ Inpatient 2 ☐	] ER/Outpatient	3 🗌 DO	A Other 4	Qursing H	ome 5 Residence	6 ☐ Other (Specify)
5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М 2	Bc. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how inju	ury occurred
6 ☐ Could not be determined	28e. Place of Injury - At h	ome, farm, street,	factory,	office		28f. Location (Street a	and Number or Rural Route Number,

building, etc. (Specify) City or Town, State)

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License numbe 02 0.7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chinten Description Desal

32. Registrar's Signature

D

State Registrar

within 24 hou To the Fune completely fil

the

2

		For	•	at in Black In aryland / Depa		lealth a	and M		/giene	ible.	0000
Physicia	n	1. Decedent's Name (First, Middle, Last) Barbara L.	Deems	001	tineate or i	Jean		2. Date of De Month Feb.	Reg. No. 2	O Year	3. Time of Death 5:30p M
/Medica Examine		4a. Facility Name (If not institution, give str 617 Highvilla			4b. City, Town, or	ex	of Death		4c. Count Bal	y of Death	re
Funeral Director		217-30-0900	7. Ag	e (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	if Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D July	rth lay, Year) 3,1941	9. Birthpl Count	ace (State or Foreign try) MD
he Maryland 28a-f show	Director	Usual Residence of Decedent  10a. State  MD  Baltimo	re	10c. City, Town or Lo	ssex				10g Citizen of		0d. Inside City Limits 1 ☐ Yes 2X No
h with th		10e. Street and Number 617 Highvilla	Road		10f. Zip Code 2122	21			10g. Citizen of	USA	try?
al", o	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent of Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No I	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∑No	ispanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)		ace - America ack, White, e ify: Whi	tc.
thin 72 hourse.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done o DO NOT use retired emaker	durina mos	st of work	ing	16b. Kind of E		lustry
	Be Con	12th  17. Father's Name (First, Middle, Last)		НОШ	emaker				e, Maiden Surna		
should ind Men marke marke	ပ	Dugan L. Alle  19a. Informant's Name/Relationship (Type		19b. Mailii	ng Address (Street				Grimm ber, City or Town	n, State, Zip	Code)
l and 2: Health a		Barbara L.	Dixon/d	laughter		ghvi		Road	Baltim		ID 21221
Pages nent of it ant; if ite ury or of		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	of Fait	e) Lh		5/09		ville	
permit. Departi		21. Signature of Funeral Service Licensee	P	22	2. Name and Address Connel						to. MD
Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Due to (or as	the death. Do not entered to the death. Do not entered to the death of the death of the death of the death of the death of the death.		_			arrest,		Approximate Interval Between Onset and Death
	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Met	tasta a consequence of):	tic.	lu	~~	Co	me	ev'	
The law requires that the death certificate be ate has been signed by the attending physicic bage 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome  1  Live birth  4  Pregnant a  9  Unknown	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у				ate of delive flonth	ry Day Year
w requires that sheen signed should be det	þ	Part II. Other significant conditions control	ibuting to death b	ut not resulting in the u	nderlying cause give	en in Part I	l. 		tobacco use cor Yes 2 ☐ No	ntribute to th	e cause of death? ably 4 Unknown
	se Completed	25. Was case referred to medical				26. Place	e of Deat	24a. Was auto perf 1 □ Yes h (Check only	opsy ormed? 2/XINo	. Were autor prior to cor death? 1 ☐ Yes	osy findings available inpletion of cause of
or Attending Phys after death. Director: After this I in by the funeral dii	ertification: To B	examiner?  1 Yes 2 No  27 Manner of Death  1 Noterial 5 Pending investigation  3 Sulcide 6 Could not be determined	28a. Date of Inju (Month, Da	y, Year) Injury	f 28c. Injur Worl M 1 🗆	4 🗆 INI	No	28d. Describe	sidence 6 O how injury occu (Street and Num own, State)	irred	
e Hospital 24 hours e Funeral letely filled	Medical C			of my knowledge, deat f examination and/or in ated.							
To the within To the comp	Me	29b. Signature and title of certifler	J. S	INTER	29c. Licens		۲ I C	05	29d. Date sign	ed (Month, I	Day, Year)
5		30. Name and address of person who com	pleted cause of d		Print)	irns		Be	ud.	ND	12122
Stat Registra		31. Date filed (Month, Day, Year) FEB 0 3 2009	32. Registr	ar's Signature	W.						

09-00927 Kendrick Danev

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

endrick Dariey	F	I- For State Classificate of Death Registrar	Reg	. No. 200	9 0269
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last)  Kendrick L. Daney	2. Date of Death  Month  February 1,	Day Year	0706 hrs
Caroa: Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	T Cordary 1,	4c. County of Death	
		University Hospital Baltimore	le p : (pin	(MM/DD/YYYY) 9. Bir	h-less/State or
Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday	5/5/197	Foreig	
any	-	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
daryland 28a-f show any 1 at once.	5	MD Baltimore Gwynn Oak			1 Yes 2 No
th the Maryl 23a or 28a-1 notified at o	Dire	10e. Street and Number  56.1.1 Haddon Avenue  10f. Zip Code  21.207		. Citizen of What Coul	
<b>215-0036</b> be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f she cut, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	ecify Yes or No- Rican, etc.)	White, etc.	rican-American
nours aft	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use retire		16b. Kind of Business/	Industry
5-0036 led within 72 letygiene. Other than "to the Medical E	Completed	Elementary/Secondary (0-12)  12th  College (1-4 or 5+)  Truck Driver		Allied Tru	king
15-003 filed within Hygiene. d other th		17. Father's Name (First, Middle, Last) 18.Mother's Name			
그 모든 물 집	o Be	Lione   Deney   Arg.   19a. Informant's Name/Relationship (Type, Print )   19b. Mailing Address (Street and Number or R	ene Baker urai Route Numb	er, City or Town, State	e, Zip Code)
MD 2 nd 2 shou alth and 1 m 27 is r	Ηī	Nicole A. Coleman Daney/Wife 5611 Haddon Avenue, Gwn	n Oak, MD	21207	
Fie Fie		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)  WoodLawn Cemetery 2/7/	′09	20c. Location - City or Woodlawn, N	ď
Baltimo permit Page Department o Important: injury or oth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility WY LI			Balto. Co.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer	1	Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries  Due to (or as a consequence of):	10		Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			-
	Examiner	cause. Enter Underlying Cause (Ulsease or Injury triat Initialiaeu events resulting in death) Last  Due to (or as a consequence of):	-2017-4	345	
ox 68760, eath certificate be executed attending physician and for use as the burial - transi		d		<del> </del>	<del> </del>
60, ate be ex hysiciar	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	y
687( ertifica ding ph	ian/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	ncy	Month	Day Year
Box 687; death certification but attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown 9 Unknown			25
9 - 9	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	the cause of death?
ords, P w requires t as been sign should be o	eted		24a. Was a		utopsy findings available
e faw r te has b ge 2 sh	Completed		autops perform	ned? death?	completion of cause of
tal Rec rcian: The certificate rector, page	Be Co	25. Was case referred to medical 26.Place of Death (Check	only one)		
'hysici	To E	1 V Yes 2 No		Residence 6 Other	er:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		Natural 5 Pending Feb 1, 2009 00211115 1 Yes 2 No	Subject stab		
Divisic pital or Atte ours after des teral Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, St	ate)	ural Route Number, City
Ospital hours a umeral ly filled		29a Certifier		man Street, Baltimo	
To the Hospital within 24 hours. To the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a	and place, and due to t	he cause(s)
E S E S	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		O.C.M.E.		February 2, 200	9
4		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
	tate	0 0 0000 M			
Regis	well	FEB. 11 2 20119 ( Assure) D. Agrand			

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Cer	tificate of I	Death	Re	g. No. 200	9 02698	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Laura Elton				2. Date of Death Month <b>January</b>	Day Year	3. Trime of beath U	
,	/Medic Examin		4a. Facility Name (If not institution, give street and 13246 Copland Court	number)	4b. City, Town, or Silve	r Location of Death er Spring	January	4c. County of Dea Montgor	ath	
	Funeral Director		5. Social Security Number 022-12-2543   6. Sex 1 □ M 2√2	7. Age (In yrs. last birthday) F 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 06/2/192	9. Bi (C) (2) (2)	rthplace (State or Foreign ountry)  MA	
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County Montgomery	10c. City, Town or Loc	Silver	Spring			10d. Inside City Limits <b>IXX</b> es 2 ☐ No	
	h with th	al Dire	10e. Street and Number 13246 Copland Court		10f. Zip Code 2090	04	10	0g. Citizen of What Country? USA		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be refitted at	by Funeral Director	1 Never Married 2 Married 1 Yes,	lForces? in	Nas Decedent of H fYes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify: <b>Port</b>	Rican, etc.)	14. Race - Am Black, Whi Specify:		
215-0	within 72 ho iene. • than "natu the Modical	Completed		(Give life. L		oation during most of work d)	ing	16b. Kind of Business	·	
Baltimore, Maryland 21215-0036	2 should be filed wii n and Mental Hygien is marked other th raumatic event, the	Be	12 17. Father's Name (First, Middle, Last) Benjamin Gomes	HO	memaker	18. Mother's Name	e (First, Middle, M	faiden Surname)	Organization	
Maryl	nd 2 should be i alth and Mental 27 is marked o r traumatic eve	To	19a. Informant's Name/Relationship (Type. Print) Tammie Thompson / Daug					City or Town, State,		
more,	permit. Pages 1 and 2:3 Department of Health a Important: If item 27 is any injury or other trat		20a. Method of Disposition  1 ☐ Burial 2 ② Cremation 3 ☐ Removal fr  4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Disposementery, crem Ardent Cre	natory or other place	<sup>(ce)</sup> 2/1/2		20c. Location - City o		
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee DOI	rota Marshall 22	Maryland	ss of Facility I Crematio 1413, Balt	on Servic	ces D 21203		
	Physician /Medical		23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of immediate Cause (Final disease or condition resulting in death)  Due	nat caused the death. Do not entron each line.  to (or as a consequence of):					Approximate Interval Between Onset and Death	
	Examiner  pu  ususit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	LIGHTLY PUBLIC OFF.	Luc					
68760,	rtificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last Due	e to (or as a consequence of):						
O. Box 68	death ce e attendii id for use	Physician/Med	in the past 12 menths?		Ectopic pregnand Other (specify)	ру		23d. Date of d Month	elivery Day Year	
σ.	law requires that the deas been signed by the 2 should be detached	þ	Part II Other significant conditions contributing	7	nderlying cause giv	en in Part I.	23e. Did tob	V _	to the cause of death?  Probably 4 Unknown	
Division of Vital Records,	The lay	Completed					24a. Was ar autops perform	y prior to ned2 death?	autopsy findings available o completion of cause of	
Vita	Physiclan: The this certificate rat director, pag	Be	25. Was case referred to medical examiner?		Oth	or:	th Check only one			
Jo I	g Phys er this eral dir	n: To	27. Manner of Death 28a. D	I ☐ Inpatient 2 ☐ ER/Outpatier  Date of Injury  Month, Day, Year)  28b. Time of Injury	IL 3 L DOX	ry at		ence 6 ☐ Other (Sp w injury occurred	pecify)	
ivision	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. P	lace of Injury - At home, farm, struilding, etc. (Specify)	M 1 □	]Yes 2 □No	28f. Location (Str. City or Town	reet and Number or i n, State)	Rural Route Number,	
_	Hospital 24 hours a Funeral I	Medical Ce	(Check only 2 Medical Examiner: On t	o the best of my knowledge, deat he basis of examination and/or in manner stated.						
	To the within 2 To the comple	Mec	29b. Signature and title of certifier  There are 1 ML	2	2997 Licens			9d. Date signed (Mod		
	5		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	its 66 0	WEN W	mison	3/, 2009	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2. Registrar's Signature	es.				•	

DHMH 17 Rev 1/2001

09-00876 Philip Freeland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ilip Freeland		- For State Amend States	ate of Maryla tems 10b,	28f Dep	artment of me fine of ertificate of	Health and Beath	Mental 19/09a	Hygiene h <b>b</b>	2 ( g. No.	09 02	69	
Physiciar	/	1. Decedent's Name (First, Midd						2. Date of Deat Month 30	Day Year	3. Time of Death 0043 hrs	h	
edical Examin		Philip Edv 4a. Facility Name (if not institution		eland	4	. City, Town, or	Location of D	January <del>25</del>	4c. County of	-		
		Union Hospital	, g. 70 0. 00 t a. 10			Elkton		"	Cecil			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Yea			h(MM/DD/YYYY)	9. Birthplace (State or Foreign		
Director		219-86-1930	1_ <b>X</b> M 2_F		34 Yrs.	Months Days	s Hours	Jan.	3, 1975	Country Maryla	and	
any	211	Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Location	n ·				10d. Inside City		
≥		,	Cecil		erryville					1 Yes 2	XNo	
Maryland 28a-f show	Ulrector	Maryland HA: 10e. Street and Number	<del>1010</del>		STIANITIE	10f. Zip Code	,	10	g. Citizen of Wha	t Country?		
ting the		503 Piney Po	oint Drive	е Е.		21903			United St	tates		
th with	nneral	11. Marital Status		cedent Ever in	U.S. 13. Was	Decedent of His s, specify Cubar	panic Origin? n, <b>M</b> exican, Pu	(Specify Yes or No- uerto Rican, etc.)	14. Race - White,	American Indian, Black etc.	к,	
er deat	<b>-</b>		1 Yes	2 No	1	Yes 2 X No	specify:		Specify:	White		
urs aft	<u></u>	15. Decedent's Education (Spe	or Dates:		16a. Decedent	s Usual Occupa	tion (Give kind	d of work done	16b. Kind of Busi			
72 hours m "natur	턀	Elementary/Secondary (0-12)	College (	(1-4 or 5+)		st of working life	. DO NOT use	e retired)		4 22114		
yo3( within iene. er tha	Completed	12			Carr	enter	40 Mathada A	Name (First, Middle, N	Constru	<u>uction</u>		
filed of Hyge ed oth		17. Father's Name (First, Middle							·	en Sumanie)		
2 P P E 5	o Be	Edward Leroy 19a. Informant's Name/Relation	ship (Type, Print )	1	19b. Mailing	Address (Stree	et and Numbe	ara Ketne. r or Rural Route Num	ber, City or Town	, State, Zip Code)		
re, MD 2 1 and 2 shou Hearth and N fitem 27 is n		Barbara Ethre	edge / Mot							MD 21903		
ore, M jes I and 2 of Health: If item 2		20a. Method of Disposition  1 X Burial 2 Crematic	Removal		o. Place of Disposi crematory or oth		metery,	Feb. 2,	20c. Location - 0	City or Town, State		
Baltimore, permit Pages I an Department of Her Important: If ite njury or other tr		4 Donation 5 Other S	Specify:		elAir Men	orial G	arden	2009	Bel Air	r, Maryland	<u>1</u>	
Baltimo permit, Page Department o Important; injury or oth	- 1	2 Signature of Tuneral Service			22. N	ame and Addres Ins Fune	s of Facility <b>ral Ch</b>	apel & Cre	emation S	Services-Be	elAir	
Physician	$\dashv$	23a. Part I. Enter the disease of	r complications that	caused the dea	ath. Do not enter th	lewport e mode of dying	Drive, such as card	iac or respiratory arr	est, shock, or near	21050 Approximate li	Interval	
/Medical		failure. List only one cause Immediate Cause (Final diseas	e on each line.		arcotic					Between Ons Death	set and	
xaminer		or condition resulting in death)	Due to (or as	a consequence	e of):		100	1 10		la la		
	١,	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	e of):			200				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e c									
cuted and transit	Exa	events resulting in death) Last	Due to (or as	a consequence	e of):					-		
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	Фŀ	IF FEMALE:	23c. If yes	, outcome of pr		ermn, g	000 27	12/07 11	23d. Date of d	delivery	-	
lox 6876( leath certificate attending phy.	an/	23b. Was decedent pregnant in past 12 months?	LIVE	birth gnant at time of	-1	al death 3	Ectopic p	regnancy	Month	Day Ye	∍ar	
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i, P.O. B		Part II. Other significant cond	itions contributing	to death but no	ot resulting in the u	nderlying cause	given in Part			oute to the cause of dea		
irres th	od be							1Ye		Probably 4 V Unk		
cords law requirents been a should								24a. Was	osy pr	/ere autopsy findings av rior to completion of cau eath?		
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of Vital Records, ing Physician: The law require Mer this certificate has been suneral director, page 2 should the	Be	25. Was case referred to medic examiner?	Hospital:		A EDIO 4 still		Othor	heck only one) Nursing Home 5	Residence 6	Other:		
n of Vi	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Dat	e of Injury	✓ ER/Outpatient 28b. Time of It		ury at Work?		how injury occurre			
on c ending sath or: Af	ertification:		nding Fd	th, Day,Year) 1/29/09	Fd 11:	30 pm.¹□	Yes 2X N	o unk				
Division tall or Attending as after death all Director: Alled in by the fi	lica	X		ace of Injury - A	t home, farm, stree			28f. Location (	Street and Numbe	er or Rural Route Number	er City	
Division  Bospital or Attence As Hours after death  The Enneral Director:  Rely filled in by the	Cert	4 Homicide det	ermined (Specifi	y)	ouse			Perryvi		115 Kirk R	oad	
the the uple	dical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examination	ledge, death occur n and/or investigat	red at the time, of ion, in my opinio	late and place n, death occu	e, and due to the causered at the time, date	se(s) and manner and place, and du	as stated.  Let to the cause(s)	921	
To With	Me	29b. Signature and title of certif		Julion,		29c. Licen	se number			ed (Month, Day, Year)		
		Tanjeti / rea	hall, MD			0.0	.M.E.		January 30	, 2009		
04		30. Name and address of person Pamela E. Southall,		t Medical E	-	1 Penn Stree	et, Baltimo	re, MD 21201				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Country Days Hours 776 M 2□ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinary ust be notified at 1 ☐ Yes 🏋 No Funeral Director HRYLAND 10g. Citizen of What Country? 10e. Street and Number 2116 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 250 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 💥 No Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) of Health and Mental Hygiene. Elementary/Secondary (0-12) SPRINTLONDUMILATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4011B 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot → Burial 2 Cremation 3 Removal from State 3/20/3752 FIB.2 4 ☐ Donation 5 ☐ Other (Specify) 21. 11 of Funeral Service Licen see 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a □Yes 2□No o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 Probably 4 Unknown icate has been signated by page 2 should b 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident filled in by the 6 □ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State

Registrar

FFB 0 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

				For State Registrar		,	Ce	ertificate of	Death		Reg	g. No.				
				Decedent's Name (First, Middle,	Last)						Date of Death Month	ath 3. Time of Death Day Year			Death	
	н	Physici		Charles H. Frey				J	anuary	27, 20	009	2:10	AM M			
		/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town, or Location of Death 4c. County of Death								
V	A S		37	Homewood Nursin	ng Home			Frederi				Frede	rick			
	, arts area.	Funeral Director		5. Social Security Number 193–14–8744	Sex 7. Age 1 7. Age	(In yrs. la	as <i>t birthd</i> a Yrs.	y) If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min. J1	Date of Birth (Month, Day, ) uly 14,	Year) 1920	9. Birthp Coun Penn:	lace <i>(Stat</i> e o. <i>try)</i> Sylvan	r Foreign ia	
		pu ,		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or	ocation					1	0d. Inside Cit	tv Limits	
		arylar show dat	_	,							1 □ Yes 2√2 No					
		8a-f	sctc	MD Freder	ick	1	Frede				10	g. Citizen of V	What Cour			
D		leath with the Marylar ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 7401 Willow Road	#421				702		USA					
2.15		ems er m	iner	11. Marital Status	12. Was Decedent Ev Armed Forces?		3. 13	B. Was Decedent of I If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Specify n, Puerto Rica	Yes or No- an, etc.)		e - Americ k, White,	an Indian, etc.		
4	21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther the Medical Examiner must be notified at	by	1 ☐ Never Married 🌋 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1X Yes 2 □ No If Yes, Give Year or Dates:	43-4	47	1 ☐ Yes 2 🔀 No	Specify:			Specify	wh	ite		
9	5-0	72 hc natu dical	etec	15. Decedent's (Specify only highest	Education grade completed)	1	16a. Dec (Gi	cedent's Usual Occu ve kind of work done . DO NOT use retire	pation <i>during mos</i>	t of working	1	6b. Kind of Bu	isiness/Ind	dustry		
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+		lygier lygier ner tl	ပ်	12 17. Father's Name (First, Middle, L	5+		pn	ysical sc			irst, Middle, M	goveri			_	
	and	be fi	Be	•						,			,			
<u>~</u>	Ž	2 should and Mer is marke aumatic	2	Charles Haverst:			19h Ma	iling Address (Stree			Evans	City or Town.	State. Zir.	Code)		
0	Ma	d 2 s th an t7 is i		Sally Frey/spot				Willow R				-	2170			
121/09	é,	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical		20a. Method of Disposition		20b. Pl	ace of Dis	position (Name of rematory or other pla		Date		Oc. Location -				
	Baltimore, Maryland	0 0		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (Sp	ecity)	,										
0.0	Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service I	Wade, Dire	ctor		22.Name and Addr tate Anat altimore			55 W. 1	Baltimo	ore S	treet		
0.0		16 24		23. Part1. Inter the disease, shock, or heart failure. List of	om lic frons fra caused t	he death	. Do not e	enter the mode of dy	ing, such as	cardiac or re	espiratory arre	st,		Approximat Interval Bet	e ween	
		Physician		Immediate C	10	ch	٠	12 Co	sa.	omi	1000	Ly		Onset and I	Death 1 F	
		/Medical		resulting in death)	Due to (or as a	consequ	ence of):		6	1		- (		-	<del>")</del>	
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-7-		D #	ner	Esquerifially list our difference, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ience of):	1				/		1	7	
PLI		ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	e to (or as a consequence of):								*		
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Charle	Box	± 50 €	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at t	2 🗌 Fetal	l death	3 □Ectopic pregnan 5 □ Other (specify)	су			23d. Date of delivery Month Day Year				
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00);	Division or Vital Records, F	The law requires that the death cerate has been signed by the attending page 2 should be detached for use	5	Part II. Other significant condition	ns contributing to death bu	t not resu	ulting in the	e underlying cause g	iven in Part	l.	23e. Did tob 1 ☐ Ye	acco use con s 2 □ No	tribute to t		death? <del>Ja</del> known	
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a	R	sician: The law certificate has rector, page 2 s	Completed	Okteo	201051						perform	ned?	death? 1 ∐ Yes			
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5	S U	Attending Physician: death. ector: After this certifica	ion:	27. Manner of Death  Natural 5 Pending investig	28a. Date of Injury (Month, Day)	Year)	28b. Tim Injui	y W	ork? ⊡Yes 2.⊑	1	d. Describe ho	w injury occur	reu			
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1 %	Οį	s after al Dire	Certification:	4 Homicide determi	building, etc	. (Specif	y)				City or Town	, State)				
known to physicia wo		To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical (	29a. Certifier CertifyIng (Check only 2 Medical sone)	Physician: To the best of xaminer: On the basis of and manner sta	examina	wledge, detailed	eath occurred at the r investigation, in my	time, date a opinion, de	and place, an- eath occurred	d due to the ca at the time, da	ause(s) and m ate and place,	anner as s and due t	stated. to the cause(	s)	
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				30. Name and address of person		ath (Iten	23a) (Ty	pe, Print)					1	1		
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			ate	31. Date filed (Month, Day, Year)	32. Registra	ır's Siana	ture	Kel								
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2:15 p

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year HARRY C. FARMER 1:13 A /Medical JANUARY 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAY RIDGE HEALTH CARE CENTER <u>ANNAPOLIS</u> ANNE ARUNDEL 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1XM 2□ F Director 93 230-05-8590 23, 1915 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits death with the Marylar show r 28a-f sh notified 1 X Yes 2 □ No Director ANNE ARUNDEL ANNAPOLIS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 900 VAN BUREN STREET 21403 USA Funeral items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 | Yes | 2 | No1 / 1943 If Yes, Give Year or Dates: | 2 / 1946 Pages 1 and 2 should be filed within 72 hours after "natural", or it 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify <u>م</u> 3 Widowed 4 □ Divorced BLACK Completed th and Mental Hygiene. 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH CHEFGOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ MAMIE L. WATERS HARRY FARMER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t; If item 27 is y or other tra 6806 GENEVA LANE TEMPLE HILLS, MD 20748 MELVIN S. YATES, SR. SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important; If any injury or once, 4 Donation 5 Dother (Specify) HARMONY MEMORIAL PARK 01-27-2009 LANDOVER, MD 21. Signal 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD20746 23a. Part1 Onter the disease or heart failure. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. disease, or o failure. List ont shock Cause (Final **Physician** an dvance disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of) attending physician for use as the burial IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown ed by t signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 00 3 ☐ Probably 4 ☐ Unknown 24a, Was an 24b. Were autopsy findings available page 2 s

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Certification: To n 24 hours after death.

le Funeral Director: A
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Saltimore, Maryland 21215-0036

			prior to completion or caus										
			performed? death?  1 Yes 2 No 1 Yes 2 No										
5. Was case referred to medical	26. Place of Death (Check only one)												
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	ospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)											
7. Manner of Death  1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred										
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Numbe City or Town, State)										
			, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)										

29c. License number

1)0063681

29d. Qate signed (Month, Day, Year)

3 0

completely within 24

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20783 1835 UNIVERSITY BLVD E. HYATTSVILLE, MD KURUP, MD

31. Date filed (Month, Day, Year) State FEB 0 3 2009 Registrar

29b. Signature and title of certifier



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30, 2009 2:50 P January Marie Anna Franz /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner North Arundel Nursing Home Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1□M 🏋 F Months Days Hours Yrs. 26, 93 Director 213-01-1157 Jul. 1915 Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lajury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 117 Linwood Avenue 21061 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jospeh Baroch Josephine Duchek ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Overcash - Daughter 117 Linwood Avenue, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, Maryland 2. Crematory 2-4-2009 Gien Burnie, Mary 22. Name and Address of Facility Ambrose Funeral Home, Inc. of Funeral Service Lit. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐Live birth Month in the past 12 months? Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 no 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ne 24a. Was an autopsy 1□ Yes 2 **(1)**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Tes 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and fitte of certific 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Madisa Park Orive, Gles MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 3 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Patricia Mae Fite January 25,2009 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges 12700 Cedarbrook Lane Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F 218-88-3236 Director 47 December11,1961 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Exercines must be notified at 10a. State 1 ☐ Yes 2 ☐ No Director Prince George's Laurel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 12700 Cedarbrook Lane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 □ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland Psychological Elementary/Secondary (0-12) College (1-4or 5+) Association 12 Public Relations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Mary Biewer Raymond Porter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12700 Cedarbrook Lane, Laurel, Maryland 20709 Paul Fite - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 1/29/09 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. KaufmanFuneral Home, Inc. 7250 Washington Blvd, Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that oxised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed signed by the attending physician and it be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 🗆 Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐No 2 Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide 15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 76,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <sub>Dr</sub> Edward Lee, 11065 Little Patuxent Parkway, Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last, 2. Date of Death Month Year **Physician** 2: 11 PM 2009 Januar 28 /Medical Name (If not institution, give street 4b. City, Town, or Location of Death County of Dea Examiner Burnie Glen C tune ltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. North Carolina Director 577-52-8869 69 1939 May Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 ☐ Yes 🏖 No Director Maryland Howard Elkridge 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 6696 Aspern Drive 21075 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò ð If Yes, Give Year or Dates: US Army 1 ☐Yes 2 1 No Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Leonard French Mary Mims ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen French - Wife 6696 Aspern Dr., Elkridge, Maryland, 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 2/2/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, In . 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** week disease or condition resulting in death) /Medical (or as a consequence of Examiner eumonia Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached f 1 □Yes 2 □No 9 ☐ Unknown 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 2 After this certificate funeral director, pag 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

law requires that the death certificate be executed Box 68760, P.O. I Division of Vital Records,

within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificatompletely filled in by the funeral director, p

State Registrar

Medical

and manner stated.

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Item 23a) (Type, Print) 01

Glen Burnie, MD 21061

4 Homicide

(Check only one)

29a. Certifier

32. Registrar's Signature

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	State of Maryland / Department of Healt	th and Mental Hygiene

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			Registrar  1. Decedent's Name (First, Midd	fle, Last)				incate of t	Journ	2. Date of Death 3. Time of Death					
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	/Medic Examin	_	4a. Facility Name (If not institution						Location of Death		_	unty of Death			
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	Funeral Director		5. Social Security Number 218–26–1797	6. Sex 1 1 N	/ 2□F	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 02/11/1	Year) 931	Cour	lace (State or l stry) yland	roreign	
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Maryland 21215-0036	thours		15. Decede	nt's Educat	tion	es.	16a. Dece	lent's Usual Occup	ation		16b. Kind	of Business/Inc	dustry		
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altimore,	es 1 a of Hea		20a. Method of Disposition			20b. F		sition (Name of natory or other place		Date		tion - City or To			
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Balt	permit. Depart Import any inj		21. Signature of Funeral Service  Market Area	e Licensee				Name and Addre	ss of Facility Hu ens Avenue	ubbard F				29	
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7	uted i insit	Examiner	Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>K</b>	200 (0	40 4 0511004	201.00 01,1			CERTIFICATION	, any me				
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	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Med	one) 29b. Signature and title of certif	ier	and mann	er stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)		
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	4		30. Name and address of person	on who com	npleted cause	e of death (Ite	m 23a) (Type,				01/2	3, 2005			
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DHMH 17 Rev 1/2001

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Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 □ M 2 🛛 F 12/27/1928 Maryland Director 220-24-6940 80 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County oriant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examination unst by indiffed at 1 ☐ Yes 2 🕅 No Pasadena Anne Arundel MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 223 Circle Road 21122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗖 No Specify: White by Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Õ Secretary Administrative 12 should be filed with and Mental Hygier 17 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic many Lillian E. Auble George Grieves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly R. Rennie / Daughter 223 Circle Road, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/31/2009 Bayview Crematory Baltimore, Maryland 21. Aignature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoxic respiratory **Physician** /Medical Due to (or as a consequence of): DAYS Examiner De compensate if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 X No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 A. Mekonen, M.D yasu Eyasu A. Mekonen, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month; Dag, Year)

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MD

Avenue

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieney 02708 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Michaux Grammer 0122 AM 2009 January /Medical 30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Harbo-Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 11/05/1921 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Days Hours Director 218-01-7451 87 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mydical Experiment sust by notified at MD Baltimore 1 □Yes 2X No Director Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or 561 Sarah Avenue 21090 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ۾ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ns any Injury or other traumatic event, In Modie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Grammer Cora Lee Clark ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry L. Berry (Daughter) 561 Sarah Avenue, Linthicum, Maryland 21090 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCUD **Physician** unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 10 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) exammer? 1 ☑ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 ☐ Medical Examine On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H000649 January 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Scheraga 31. Date filed (Month, Day, Year) 3001 S. Hanover St. Baltimore MD 21225 D.0 State 0 3 2009 FEB Registrar GRECUR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 23, 200<sup>r</sup>g<sup>ar</sup> **Physician** 6:50 AM M William Gales /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min unk 1 🔀 M 2 🗆 F 579-28-7558 82 Director Sept 19, 1926 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show colon Examirat nust be notified at 1 ☐Yes 2√ No Director MD Forestville Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 USA 7420 Marlboro Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status unk ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2🗓 No Specify: black Specify: ģ 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20735 7503 Surratts Road Clinton, MD Southern Maryland Hospital permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State in state 4 ☐ Donation 5 🖾 Otner (Specify) 21. Signature of Euneral Service S. Wade Director 28 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seite cerniq Physician disease or condition resulting in death) /Medical Due to (rr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): burial-1 the attending physician the dria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. □Yes 2□No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 æ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy performe 21 No certificate 1 ☐ Yes 2 1 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manyler of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one)

e Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifica completely filled in by the within 2

> State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

29b. Signature

Southern 1328 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Swh 310

29c. License number 10055120

Washington DC 20032

29d. Date signed (Month, Day, Year)

23 2009

State of Maryland / Department of Health and Mental Hygiene) በ በ 0 02710 For State Registrar amend 8 per F.H. g888 2/20/09 rtifle ate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Avery Sheldon Groves 5:25 PM 25 2009 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 124/31/08 Sinthplace (State or Foreign (Month, Day 1/24/31/08) Maryland 5, Social Security Number 6. Sex **Funeral X**XM 2□ F none Director Maryland Usuel Residence of Decedent 10c. City, Town or Location 10a. State is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene.

Health and Mental hygiene is the file of the search of the file of the search of the than "natural", or items 23a or 23a-1 show other tranmatic event, the Medical Example mast technified at 10b. County 10d. Inside City Limits Baltimore Maryland Rosedale 1 ☐ Yes XXNo Director 10e..Street and Number 10g. Citizen of What Country? 10f. Zip Code 2 Parham Circle 21237 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ξ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sheldon Lamont Groves Amber Melanie Sparrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trea once. Amber M. Sparrow 2 Parham Circle, Rosedale, MD 21237 (mother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 🎇 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Gardens of Faith 2/2/2009 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician EXTREME Prematarity 25 days resulting in death) /Medical Due to (or as a consequence of): **Examiner** EVERE respiratory Distress SCULFE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed Renal failure that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 Yes death 2 Accident within 24 hours after death To the Funeral Directors filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) -000 43985 Melle 1112 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin MO Franklin Square SUSAN J. DULKERIAN Hespital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 03 2009 Registrar

			For State	State of Mar	-	partment of F Certificate of I		-	giene Reg. No. 2	nna	02711		
			<ul> <li>Registrar</li> <li>Decedent's Name (First, Middle, La</li> </ul>	st)		er inicate or i	Jean	2. Date of De		003	3. Time of Death		
	hysicia /Medic		Richard R.	Gallahan				Janua:	ry 30,	2009	3:20 PM		
	xamin		4a. Facility Name (If not institution, given) 931 Burnett Avenu	· ·		4b. City, Town, or	Location of Death	4c. County of Death Anne Arundel					
Fu	ineral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp	place (State or Foreign		
	ector		223-00-7011	M 2□F	55 Yrs	Months Days	Hours Min.	May 10	, 1953	Cour	VA		
land	MQ III		Usual Residence of Decedent  10a. State 10b. County	1	I Oc. City, Town or	Location	<u> </u>			1	0d. Inside City Limits		
Mary	a-f sh	ctor	MD Anne Aru	ınde1		Arnold					1 □Yes 2 □ No		
th with the	23a or 28 ust be rio	al Director	10e. Street and Number 931 Burnett Aver	iue		10f. Zip Code 2101	2		10g. Citizen o	f What Cour SA	itry?		
Dailillore, Marylaillo 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or items Evaminar m	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: U		3. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 1 No	ace - Americ ack, White, hify: Wh:						
72 ho	"natur	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Marketing  16b. Kind of Busing (Give kind of work done during most of working life. DO NOT use retired)  Marketing  Election									dustry		
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Mary d 2 shoul th and M	7 is mar traumati	F	19a. Informant's Name/Relationship ( Alexa B. Gallah	Type. Print) nan / Wife		ailing Address (Street  1 Burnett			-		Code)		
altillore, mit. Pages 1 an partment of Heal	ant: If item 2 ary or other		20a. Method of Disposition  1 □ Burial 2 【2 Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State	20b. Place of Di	sposition (Name of crematory or other place Crematory		Date	20c. Location				
parti. Departin	Importa any Inju once.		21. Signature of Funeral Service Lice	Dorota Ma	arshall		ss of Facility Crematic 413, Balt			03			
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To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death.	/ the attending p ched for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. C	ery Day Year							
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or Atter	l Director d in by the	Certification:	3 Suicide 6 Could not be determined	e 290 Place of Injur	y - At home, farm, (Specify)	, street, factory, office			Street and Nur wn, State)	nber or Rura	al Route Number,		
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To th within	To th	Me	29b. Signature and title of certifler	MD		29c. Licens	e number	7.	29d. Date sign	1			
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4	7		30. Name and address of person who	Tay Rhu	atn (Item 23a) (Ty	pe, Print) Bestgeh R	2 Suite 3	U) Ann	my 2	1401			
F	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 2 2009	32. Registrar	s Signature	Mad			*	•			

			For State Registrar	State of Maryla		artment of F			ene g. No. 2	009	02712		
	Physicia		1. Decedent's Name (First, Middle, L BEVERLY	ast)	GREENFE	LD		2. Date of Death		2009	3. Time of Death 12:50 A M		
	/Medic Examin		4a. Facility Name (If not institution, g. 9715 TULSEMERE			4b. City, Town, o	r Location of Death		4c. County of Death BALTIMORE				
ı	Funeral Director		212-36-8169	Sex 7. Age (In you	rs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 12/22/19	Year) 40	9. Birthp Coun	lace (State or Foreign try) NY		
Maryland of	8a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           MD         BALTI		City, Town or Lo	LSTOWN					0d. Inside City Limits 1 ☐ Yes 2 No		
this th	3a or 2		10e. Street and Number 9715 TULSEMERE	ROAD		10f. Zip Code	133	Jg. Citizen of US <i>F</i>	en of What Country? USA				
d 21215-0036	Ital Hygiene.  dother than "natural", or items 23a or 28a-f show event, the Medical Exacultural recognities at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		ace - Americ ack, White, e ify: Wh			
Baltimore, Maryland 21215-0036	jene. r than "natu	Completed	15. Decedent's (Specify only highest g	Education trade completed)  College (1-4or 5+)	I (Give	dent's Usual Occup kind of work done DO NOT use retire BOOKKEEP	during most of wor d)		PHO				
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Maryla	or other traumatic	-	19a. Informant's Name/Relationship MELISSA GREENFE					IN RD., R	-		, MD 21136		
more,	perfilt. Tayes Faited Department of Health Important; If item 27 It any Injury or other tra		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State   D	ALTIMORE	osition (Name of matory or other pla E HEBREW	02/0	1/2009	REISTE	ERSTOW	N, MD		
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rds, P	has been signed by the le 2 should be detached	by	Part II. Other significant conditions			underlying cause gi	ven in Part I.	23e. Did tol			he cause of death? cably 4 🗆 Unknown		
al Reco	ficate has bee ir, page 2 shou	Completed	OF War and a state of the last				00 Plans (Pa		ned? 2 <b>X</b> No	o. Were auto prior to co death? 1 □Yes	ppsy findings available impletion of cause of 2  No		
Division of Vital Records,	within 24 hours after death, within 24 hours after death, and within 24 hours after death, completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigat	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year	28b. Time o	of 28c. Inju	her: 4  Nursing l	ath (Check only on Home 5 X Reside 28d. Describe ho	ence 6 🗆 C		fy)		
Divis	after des	ertifica	3 ☐ Suicide 6 ☐ Could not determine		At home, farm, st pecify)	reet, factory, office		28f. Location (Si City or Town		mber or Run	al Route Number,		
	n 24 hours ne Funera pletely fille	Medical (	29a. Certifier 12 Certifying (Check only one)	Physician: To the best of my caminer: On the basis of examiner and manner stated.	knowledge, dea mination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the durred at the time, d	cause(s) and late and plac	manner as e, and due t	stated. o the cause(s)		
	Vithi Comp	M	29b. Signature and title of certifier	foroit, m.	D.		ise number		29d. Date sign	2 1	3 C		
	)			no completed cause of death ( c > + 2 M . D.  32. Registrar's S	(Item 23a) (Type	Print)	ads Di	rive St	e#34	000	vings Mills		
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 2 2009	32. Registrar's Si	ignature					4	40,2007		

Box 68760. P.O. I

Baltimore, Maryland 21215-0036

Maisey

be executed Division or Vital Records.

> Registrar DHMH 17 Rev 1/2001

State

(Check only

29b. Signature and title of certifier

KANT

31. Date filed (Month, Day, Year)

twent

RAVI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

, SINAL

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MOSPITAL OF BALTIMORE

RESOOO

29d. Date signed (Month, Day, Year)

29/09

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 239010 AROLYO January 200 0) /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Square Raitimone If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 F Months Days Hours Min. ALS 74 4760 Usual Residence of Decedent Yrs. Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. "Important: if item 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "hydical Evar, incrinual by nutflind at pine." 1 ☐ Yes 2 No Director BALTIMOR 1000200 and 2 should be filed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3133 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced My 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ZAAK ONUMOS LA ೭ 72 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town State Pages 1 ☐ Burial ② Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3000 21. Sign were 1 Funer I Service Licensee REMATTON 39042 ELEVE ENVERENT FRANSTER Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan end for use es the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) After this certificete has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) end manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Franklin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jarvan

FEB 0 3 2009

31. Date filed (Month, Day, Year)

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JANUARY

MARION HORNEY

		1	For State Registrar	State of Ma	aryland		rtmen <i>tificate</i>			ınd Me	ntal Hyg	iene :g. No. 2 (	009	02716
	Physicia		1. Decedent's Name (First, Middle, Last,								Date of Deat Month anuary	h	0 <sup>Year</sup>	3. Time of Death 8:08 PM M
	/Medica	al -	Peggy Ann Hanson la Facility Name (If not institution, give Stella Maris Hos)				4b. City, Town, or Location of Death Timonium					4c. County Balti	of Death	0.00 277
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. las	st birthday) Yrs.	If Under Months	_	If Under 2 Hours	24 Hrs. 8 Min. 0	Date of Birth (Month, Day, ct 22,	Year) 1920	9. Birthp Cour New	place (State or Foreign htry) Jersey
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dient Evaminational be notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo  10e. Street and Number  2525 Pot Spring R	10c. City,	Town or Loo	nium 10f. Zip		21093			•	10d. Inside City Limits 1 □ Yes 2√ No What Country? USA		
8:08 p.m. 215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it we death Evanting restrict on this permitted at once.	Be Completed by Funer	11. Marital Status unk  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grace)	16a. Decec (Give life. L	13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc					Specif 16b. Kind of B	ck, White,  y: wh  usiness/In	dustry		
~ ~	filed within Hygiene. <b>vther than</b> *	Sol	12 17. Father's Name (First, Middle, Last)	College (1-4or ! 5+			medic	al d	18. Mothe		First, Middle, i	heal Maiden Surnai	thcar ne)	·e
2009 land 2	ld be fi ental F ked ot ic evel	To Be	Charles W. Hanson	1							n D. Br			
23 <b>,</b> Maryl	and 2 shoul ealth and M n 27 is mar ner traumat		19a. Informant's Name/Relationship (T Patricia Chambers)									r, City or Town		0 Code) 1043
JANUARY Baltimore,	Pages 1 a nent of Her ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ፟፟፝ Donation 5 ☐ Other (Specify		20b. Pla	ace of Dispo metery, cren	sition (Nar natory or o	ne of ther plac	e)	Dai	le	20c. Location	- City or To	own, State
JAN	permit. Departr Importa any inji		21. Signature of Funeral Service Licens	rel		Ва	1time	re,	MD	21201		Baltim	ore S	
8760,	bath certificate be executed attending physician and attending physician and for use as the burial-transit	ical Examiner	Inter the disease, or complications that caused the death. Do not enter the mode or dying, such as darded or respiratory arrangements of the disease or or or difference of the disease or or or difference or or difference or or difference or or difference or or difference or or difference or or difference or or or difference or or difference or or difference or or or difference or difference or difference or dif											Approximate Interval Between Onset and Death
O. Box 6	the death certifics y the attending pl ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3[	☐ Ectopic p		у				ate of deliving	very Day Year
HANSON scords, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death	but not resul	iting in the u	nderlying o	ause giv	en in Part	l. 	23e. Did to			the cause of death?
w	The law rec ate has bee page 2 shou	Completed									24a. Was autop	an 24b sy med? 2 <b>X</b> No	prior to c death?	opsy findings available ompletion of cause of
PEGGY Vital R	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o		ther (O	ify) HOSPICE
Division of	<b>To the Hospital or Attending Physician:</b> The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of In (Month, D	lay, Year)	28b. Time o Injury	M M	28c. Injui Wor 1 🗆	ry at	]No	Bd. Describe h	now injury occu	irred	ral Route Number,
_	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the besininer: On the basis	of examinat	wledge, dea tion and/or in	th occurred	at the ti	me, date a opinion, de	and place, a	and due to the ed at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	EANP			29	C. Licens	se number	92		29d. Date sign	le Zi	n, Day, Year)
				completed cause of	death (Item			ВD	ттм	ONTIIM	, MD 21	.093	•	
1	Sta Registi		JACKIE JONES, CI 31. Date filed (Month, Day, Year) FEB 0 3 200	32. Regis	strar's Signat	ure	Mad		2.211					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Annie D. Hines January 28. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sinai Hospital Baltimore

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 C 5. Social Security Number 8. Date of Birth 12<sup>Mo</sup>13-13<sup>2</sup>36<sup>ear)</sup> 6. Sex **Funeral** 1 □ M 2 🗓 F 237-62-6283 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1XYes 2 No Baltimore MD N/A Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 USA 201 Doris Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**☐ No Specif African American Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Nursing Home 12th Nurse Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jasper Barnes, Sr. ပ Jannie Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 201 Doris Avenue Baltimore, MD 21225 Beverly Mable 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. DelightChurch Cem 2-7-2009 4 ☐ Donation 5 ☐ Other (Specify) Walstonburng, NC 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Functial Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athoroschenotic Cardiovasular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Choonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2.☐No ned by the detached P.O. 9 Unknown signed k 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 Mo 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred spital or Attending P lours after death. neral Director: After ' 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) 3 2009

29b. Signature and title of certifier

mor-Dow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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031805

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Lawrence February Fred Havercroft 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Cockeysville Maryland Masonic Home 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Days Hours 1 <del>M</del> M 2 □ F 91 June 2. 1917 541-14-8474 Oregon Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10h. County 1 ☐ Yes 2 No Cockeysville Maryland | Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21030 300 International Circle, #213 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No 1945 If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Analyst 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Brown Henry Francis Havercroft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO Box 5045, Breckenridge, Colorado <u>Roy Addison Hoff / Nephew</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02-05-09 Woodlawn, Maryland 4 Donation 5 Dother (Specify) Lorraine Park 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Funeral Service Licerue 21. Signatur 21204 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Praimon disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Vear 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 X No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

and

for use

signed by the a

The law requires that the death certificate be executed

or Attending

Hospital

within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Directo

Funeral

ò

Completed

Be

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
IF FEIVIALE.
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
0 Halanaum

25.		referred to	medical
	examiner?		
	1 ☐ Yes	2 <b>X</b> No	

27. Manner of Death 1 Natural

29a. Certifier

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3508

31. Date filed (Month, Day, FEB 0 3 2009 Registrar

DHMH 17 Rev 1/2001

10+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 1, 2009 **Physician** ELIZABETH HUGHES 4:20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore The Maples of Towson Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) 1□M 2XF Months Days Hours 220-48-5330 90 Maryland January 30,1919 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hyglene. Insportant: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any inJury or other traumatic event, he Medical Evanning must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 7925 York Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2**XX**No δ Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca E. Cole Charles E. Woollen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 945 Fairmount Ave. Towson, MD 21204 Adrian Hughes IV/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem GardFeb. 3,2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John (). Mitchell IV, Funeral Services of Dulaney Valley, P.A.
200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee eart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ceresportation accident Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performe 1 ☐Yes 2/25No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Attending uno 137016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chevks St, Sute 4105, Balthour, mo 2 rdy Kenneth n. MB Greene.

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** HARTMAN WILLIAM FEBRUA RY 02 2009 /Medical a Facility Name (If not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death Examiner MOUNT ARROL If Under 24 Hr Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**X** M 2□ F Country) Ohio 90 November 10,1918 Director 441-16-9114 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕱 No Director Florida N. Ft. Myers Lee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19430 Saddlebrook Court 33903 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc within 72 hours after 1 X Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify. þ Specify: White 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Retail Carpeting Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other trainmant. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hartman Edna Davis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12511 Lee Hill Drive Mt. Airy, Maryland 21771 Robert Clark (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐Removal from State Atlantic Crematory 5 Other (Specify) 2-3-2009 4 Donation Glen Burnie, Maryland 21. Signature of uneral Service Licensee. 22. Narge and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 01283 p cations hat cause in one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, of the shock, or heart failure. List of Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Physician Minu /Medical Due to (or nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due lorior as a consequence Examiner be executed Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? a A 3 Probably 4 ☑Unknown 1 TYes 2 TNo Completed Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Patter death. After Certification: 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

Hospital 24 hours a

the 2 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed

Medical

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

DHMH 17 Rev 1/2001

State

(Item 23a) (Type, Print)

and manner stated:

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lelia Huber January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Ac. County of Death Samare 05 8. Date of Birth (Month, Day, If Under Social Security Number Birthplace (State or Foreign Country) Days 1 □ M 2 🖫 F Months Hours 82 220-24-3389 .1926 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Essex Md Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 345 Townsend Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XSo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Spangler Margarite Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 345 Townsend Road Baltimore MD 21221 Lelia D. Huber /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 2/2/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signatur neral Service Licensee Or Connelly Funeral Home of Essex 21221 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): (Cidney work C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

W.D -21221

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Exeminer must be notified at

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Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than '

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

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Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

4 Homicide

(Check only one)

29a, Certifier

law requires that the death certificate be executed physician and s the burial-trans attending p signed by the a icate has t , page 2 s

Box 68760,

P.0.

Records,

Division of Vital

To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

NA3BRIVI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

determined

709 32. Registrar's Signature

IND.

BASTERN BLVD,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 03 P 1 a 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lattimere Washington Medical Center len Burnie Hone Hrund 8. Date of Birth (Month, Day, Year) AUG-22, 1960 (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Funeral Hours Days 240-21-7078 1 □ M 2 5 F Carolino Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Michael Examiner must be notified at 1 □Yes 2 No Burnie Director Anne 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21061 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 □Yes 2 No Specify Specify: ac by 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) gTura manas 2 should be filed w n and Mental Hygier Is marked other th WH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 is any injury or any DR. C Sisle morbente 20735 Vivian 11708 inton, mD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State t. Pages 1 1 Surial 2 Cremation 3 Removal from State -09 Cem Harnett (o. west Haven 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensée Jan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMO CUESIS CALINI PNEWMONIA /Medical Due to (or as a consequence of): Examiner ANOWIA SIZIFR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☑ No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **\**\ 1 Inpatient 2 ER/Outpatient 3 DOA ٩ After this 28b. Time of Injury 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death, ne Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENTERL MMORE NEVICITE ASHINGTON 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per \$\text{\$18} \text{\$688Ma}{\sqrt{18}} \text{\$18} \tex Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 11:00PM BETTIE HOFRICHTER ranuali 29 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE (ITY

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | 01/02/1909 HOSPITAL OF BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2√□ F 216-48-0781 100 RUSSIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A 1 VYes 2 □ No BALTIMORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3328 NORTHMONT ROAD 21244 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X☐ No Specify: WHITE ¥☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER **GROCERY** 18. Mother's Name (First, Middle, Maiden Surname)
Chana
CHANG
SHOCKF 17. Father's Name (First, Middle, Last) CHAIM BRONFIN SHOCKETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONORE CHIZEVER / DAUGHTER 3328 NORTHMONT ROAD BALTIMORE, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 02/02/2009 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD PIKESVILLE, N INC. 21208 Melt Ce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory disease or condition resulting in death) Due to (or a a consequence of) orgelling Due to (or as a consequence of): sebers Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a is any injury or other traumatic event, the Medical Experimental Process.

Baltimore, Maryland 21215-0036

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Funeral Director

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Examiner physician and the burial-trans Physician/Medical attending pl certificate has been signed by the rector, page 2 should be detached Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be Certification: To

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Sequentially list conditions, an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

25. Was case referred to medical

5 Pending investigation

6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

cal

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier KUMAR MD

RES -000 JANUARY 29 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM 20a7 22 per FH G888 2/3/09 WS ASTAR OF Maryland 7 Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:10 PM 2009 Barbara Ann Jones Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Regional Hospita Laurel George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Rhode Island 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 5, **Funeral** Months Days Hours 79 June 1929 Director 039-18-8766 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2√☐ No MD Prince George's Laurel 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20708 USA 8801 Hunting Lane #T3 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 X No Specify: White ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) secretary construction 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Jeremiah McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8801 Hunting Lane #T3 Laurel, MD George Jones/spouse Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemeter), crematory or other place.

Evans Funeral Chapel.

Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/31/2009 Forest Hill, Maryland 4□Donation 5 MOther (Specify) in state 21. Signatur Funeral Sprice Licensee 22. Name and Address of Facility Evans Euneral Chapel & Crem Svcs 8800 HartordyRd 21201 Baltimore, MD 21234 Director 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Rena Exami Moute burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) o 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, Completed by 2 No 3 Probably 4 Unknown icate has been siç , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy the Hospital or Attending Physician: The performed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dusen Road van 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:17pm JOHNSON ARNITA 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTOWN BALTIMORE NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Date of Birth (Month, Day, Year 1 □ M 2 🕱 F Months Days Hours Min. 216-14-7887 Director 18,1922 MARYLAND Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyglene.

and: If fieue 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, he "sedes Expresse rust be notified a ray or other traumatic event, he "sedes Expresse rust be notified a 1 XYes 2 ☐ No NA Director BALTIMORE MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 212 ROSEDALE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates: Specify Completed by Specify: BLACK 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COUNSELUR DEPARTMENT OF DEFENSE YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JEFFRIES HENRY ISADORA VIRGINIA ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENNIS E, HOWELL (30N) 8026 MONTWOOD RD., WINDSORMILL, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. 02/06/2009 BALTIMORE, MARYLAND DRUID RIDGE CEM. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
503EPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee non 2140 N. FULTUNAVE, BALTIMORE, MD 01217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been signi , page 2 should be t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother Specify HOSPICE 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue Suite 203 Baltimore MD 2835 Deborah 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

# State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** LEON ROSCOE JOHNSON, JR Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Plata Civista Medica a 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1√2 M 2 □ F 579-44-2662 Director 07-28-1935 Usual Residence of Decedent 1∩a State 10h County 10c City Town or Location 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the fixedical Examination must be mutified at MD CHARLES WALDORF, MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2018-A WIDGEWOOD PLACE 20602 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any lnjury or other traumatic event, ITE I Folls. ORCE. Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE WORKER PRIVATE 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEON ROSCOE JOHNSON, SR. LOTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018-A WIDGEWOOD PLACE WALDORF, MARYLAND 20602 MARY L. JOHNSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION 02-02-2009 CLINTON, MARYLAND 21. Signature of Funeral Sep 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MARYLAND 20746 Donor 23a. Part/ Enter the disease, of conshook, or heart failure. List of Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. **Physician** Cardlogenic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oxygen dependent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine be executed attending physician and for use as the burlal-tran Box 68760, Due to (or as a consequence of): Physician/Medical spital or Attending Physician: The law requires that the death certificate I ours after death. Ours after death. The law been signed by the attending physism the attending physism by the funeral director, page 2 should be detached for use as the Lifled in by the funeral director, page 2 should be detached for use as the Law the tuneral director, page 2 should be detached for use as the Law the Linear Law the Linear Section 1 and 1 a IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 12 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

26 am

2009

narles

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

MINS

1∏Yes 2∏No

WASHINGTON, DC

Division of Vital Records, P.O. To the Hospital c within 24 hours af To the Funeral Di

Completed

æ

Certification: To

Medical

Obesity

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

2 Accident

3 🗌 Suicide

29a, Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

1 Natural

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ravinder Sindhwan MD, 6 Past Office Rol

MD 6 Pos 32. Registrar's Signature

RAINDRIUM

DVT (legs)

hypoventilation

Cancer

28a. Date of Injury (Month, Day, Year)

**ORIGINAL** 

Right pulmonary

1 Department 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

with metastasis

28c. Injury at Work?

29c. License number

1 ☐Yes 2 ☐ No

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 3 2009

32. Registrar's Signature

09-00937 Anthony Jennings

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

anthony Jennings		For State egistrar	of Maryland / Departn Certifi	nent of Heal cate of Deat		ygiene Reg. l	No. 2 ∩	00 0272
Physician Medical Examine	1	. Decedent's Name (First, Middle,Las		GS	88	2. Date of Death  Month Death  February 1, 2	40	3. Time of Death 4
wedical Examine		la. Facility Name (if not institution, give			Town, or Location of Death		4c. County of Dea	th
		Sinai Hospital	To Acc (In use local heart)	Baltin		R Date of Right	M/A MM/DD/YYYY) 9. B	
Funeral Director	c	5. Social Security Number 6. Sec. 216-78-2713 1	7. Age (In yrs. last b	Yrs. Month		<del>-</del>	Fore	
nd show any		0a. State 10b. County	10c. City, Tov	on or Location  a stin	iore			10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	ē	1605 North	Twick Rd.	10f. Zip		10g.	Citizen of What Co	- '
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	ā I	11. Marital Status 1 Never Married 2 Married	1 Yes 2 No	If Yes, speci	ent of Hispanic Origin? ( S fy Cuban, Mexican, Puerto		White, etc.	erican Indian, Black, BIAC (C
ours afte	2	Widowed 4 Divorced  15. Decedent's Education (Specify or	If Yes, Give Year or Dates: nly highest grade completed) 16	a. Decedent's Usual	No specify:  Occupation (Give kind of		Specify: Sb. Kind of Business	s/Industry
1036 vithin 72 houndle for than "na Medical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		rking life. DO NOT use ret	rard.		l Police
21215-0036 ould be filed within 7 Mental Hygiene. s marked other than it event, the Medica	ne C	17. Father's Name (First, Middle, Last)	V. Jenning:	S	18.Mether's Nam	e (First, Middle, Mai	mon to	asue
Should be and Ment is mark even		19a. Informant's Name/Relationship (T	Type, Print )	19b. Mailing Address	Street and Number or	Ru Route Numbe	r. City or Town, Sta	te. p Code)
and 2 s and 2 s lealth ar item 27	-	Linda Jenni 20a. Method of Disposition	ings - EX-wife 20b. Place	e of Disposition (Na	me of cemetery,	Date 2	Oc. Location - City	or Town, State
MOTE Pages 1 ent of F int: If i		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other Specify  21. Signature of Funeral Service Lice	Removal from State	natory or other place	nest Vet 2.	-9-09	Owings "	nices, m).
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	- 1	XXMVIII II MARCO	1	(races	P. March 1	f. H. C	altoin	d. 21229
Physician /Medical		23a Part . Enter the disease, or comp failure. List only one cause on ea	ach line.	not enter the mode	of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
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		Sequentially list conditions, b.	Due to (or as a consequence of):		.**-, ·	_		
	١₽	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
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eath certificate be executed attenting physician and for use as the burial - transit		3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan  1 Live birth	2 Fetal death	3 Ectopic pregn	nancy	Month Month	Day Year
Box 687 s death certificate attending p ed for use as the	ysici	1 Yes 2 No 9 Unknown	Pregnant at time of death  g Unknown	5 Other (Spe	ecify)			
ords, P.O. B  wrequires that the d sbeen signed by the should be detached	by Physician/	Part II. Other significant conditions	contributing to death but not resul	ting in the underlyin	g cause given in Part I.	23e. Did toba		to the cause of death?
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Vital Recornysician: The law ruthis certificate has be I director, page 2 sh	Completed					autopsy perform	ed? death'	
al R	ادہ	25. Was case referred to medical			26.Place of Death (Check			
F Vit	9	1 ✔ Yes 2 No	Hospital: 1 Inpatient 2 V ER			ing Home 5 Re	esidence 6 Oth	ner:
on of anding Pluth.	<u></u>	27. Manner of Death  1 Natural 5 Pending	(Month, Day, Year)	b. Time of Injury	28c. Injury at Work?  1 Yes 2 XNo	unk	w injury occurred	
Division of Vital Records, P.O. ours after deading Physician: The law requires that the ours after death. After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	Certification:	2 Accident Investigat 3 Suicide 6 X Could not	28e. Place of Injury - At home	, farm, street, factor		28f. Location (Str or Town, Sta	eet and Number or te) 2481 Sh	Rural Route Number, City
lospital I hours a uneral		4 Homicide determine	ian: To the best of my knowledge,		e time, date and place, an	Baltimor	e, MD	
Division of Vital Records, P.O. Box 68760, To the Dospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contraction of t	Medical		er:On the basis of examination and/ and manner stated.					
	ž	29b. Signature and title of certifier		29	C. License number O.C.M.E.		29d. Date signed (A February 2, 20	
	-	30. Name and address of person who	completed cause of death (Item 23	a)				
4+1)			Medical Examiner 111 Pe	enn Street, Balt	imore, MD 21201			
Sta Registra		31. Date filed (Month, Day, Year) FER 0 3 2009	32. Registrar's Signature	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19b perFH#30perDVR, G888, 2/3/09, WS

State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death A Year Mor **Physician** Clara Belle Kroening 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore n/a | Honder 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Days Hours | Min. | August 15,1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 213-01-6644 Yrs. 91 Virginia Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 903 Beaver Bank Circle 21286 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3XWidowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 sales retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental Is marked William Beale Lumpkin Hattie Belle Elliott 19a. Informant's Name/Relationship (Type, Print) 1900 Bailing Address (Street and Number or Trigit Rute Number Mily of Tor gate, Zip Code) permit. Pages 1 and 2: Department of Health ar Importent: If Item 27 Is eny Injury or other trau QDGE. 903 Beaverbank Cir. Towson, MD 21286-3314 Byl Kroening/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Green Mount Crematory | Feb. 3,2009 Baltimore, Maryland 22. Name and Address of FacilityJohn O. Mitchell IV, Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee P.A. MD Services of Dulaney 200 E. Padonia Rd. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at id be detached for 4☐Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 🗌 Probabły s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 20 1 Yes 2□ No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes No 1 Inpatient 2 ER/Outpatient 3□ DOA this Director: After the 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Khosrow

31. Date FEB

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7601 Osler Dr. Towson,

Joseph Medical Center

32. Registrar's Signatur

AMEND #2,3&10G PER PHY G888 2/18/09 JH
State of Maryland / Department of Health and Mental Hygiene 200 02730 Certificate of Death 2. Date of Death JAN . 26 , 2009 1. Decedent's Name (First, Middle, Last) 12:40AM Day Month **Physician** reit USEP /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Nursing Home & Rehab Burtonsville Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 1 ₩ M 2 □ F 82 Sept.13, 1926 Germany **Director** 072-46-4933 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show sdien Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code AUSTRALIAN by Funeral 9730 Basket Ring Road 21045 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Specify: White 1 ☐ Yes 2 XNo Maryland 21215-0036 Specify: Year or Dates Be Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than 10 Manager Hotel Industry permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 Is marked other any injury or other traumatic event, ## 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Kreit Helene Schmitz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hildegard Kreit-Wife 9730 Basket Ring Road, Columbia, Maryland 21045 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory, Inc. 01/28/2009 Glen Burnie, Maryland 22 Name and Address of Facility
Witzke Funeral Home, Inc. 21. Signature o Funeral Servio License 5555 Twin Knolls Road, Columbia, Maryland 21045 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Meumonia **Physician** /Medical Due to ( r as a consequence of) Examiner erebrovascular isease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Completed by Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buna as ) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 1 Tyes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed this certificate 1∐ Yes 2 HNO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death

Director: 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 DO053337 1126/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 200 Reisterstown, Md 21136 Secry 25 Main Stree 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 3 2009 Registrar

**Examiner** The law requires that the death certificate be executed and burial-trar Division or Vital Records, P.O. Box 68760, attending physician the څ this or Attending after death death filled in by 24 hours a

**Physician** 

/Medical

Examiner

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

Maryland

Baltimore,

/Medical Significations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Completed 25. Was case referred to medical examiner? Be Certification: To 27. Manner of Death 1 Natural 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29ç. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

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Year)

31. Date filed (Month, Day,

State Registrar

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00711 State of Maryland / Department of Health and Mental Hygiene Anthony Joseph Kursvietis 2009 02732 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 24, 2009 0720 hrs Medical Examiner tothoni 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and nu **Baltimore County** 2913 Andorra Court #E Parkville 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Davs 10.11.1949 Director 219-52-5712 Country) 2. F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 Ne Battimore with the Maryland Director 10g. Citizen of What Country' 10e. Street and Number J.S 21234 Funeral Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be 1 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Never Married Yes If Yes Give Yaar Specify: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Yes 2 No specify: ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ MD 21215-0036 ounselor 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ursuietis Ana salatkus Anthony (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relations ip (Type, Print) Bultimore 4905 ursvietis Crowson Ave > erard 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, crematory or other place) 2/2/2009 Bultimore ML reenmount Donation 5 Other Specify: voughn C. Greene Funeral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M Bultimore, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Diabetic ketoacidosis Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) transit The law requires that the death certificate be executed and 3a,2/,perME, g888 2/12/09 b **per fh g888 2-24-09 vt** Physician/Medical X UNPENDED attending physician or use as the burial -AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Records, P.O. ģ No 3 Probably 4 V Unknown Yes 2 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has b ector, page 2 sho performed? death? ✓ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other4 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural Yes 2 Pending Funeral Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) (Specify) 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie January 24, 2009 O.C.M.E.

Registral

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

egistrar's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day, Year, FEB 0 3

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exam har nat be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1  Yes 2 N If Yes, Give Year or Dates:	lo	1 □ Yes 2 No	Specify:				can-American
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and 2 ealth a n 27 is		Vernet Wilson / Sister	in law		932 Nemo Road					<i>p</i> 0000)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 02734 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3. Time of Death Year Hinrichs Kessler 1100A M Helen /Medical JANUARY 31 2009 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAltimore Washington Median Center Glen Burrie Anne Arundel 5. Social Security Number 220-05-3691 If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 M XXF Months Days Hours Director Min. Yrs. 101 7, 1908 Jan. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 28a-f Anne Arundel Co. Linthicum 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 806 South Camp Meade Road "natural", or items 23a 21090 Funeral death United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give X þ 3 ₩ Widowed 4 Divorced 1 □ Yes 2√⊡ No Specify: Year or Dates Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) Union Brothers College (1-4or 5+) 10 yrs. Secretary Is marked other Furniture Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William 2 John Hinrichs Helen L. Gable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Mrs. Dorothy K. Reilly/Daughter 202-H Secretariat Dr. Havre de Grace, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Feb. 2,2009 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation U.QUC. Services, PA.; 1 2nd Ave. SW Glen Burnie, MD21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Neumania /Medical I wear Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy detached 5 ☐ Other (specify) Day Year 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 No 1 ☐ Yes 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Munpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Hospital or Attending 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural neral Director: Af 5 Pending Injury 2 Accident investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier turco 31,2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Francis BAHMOre M.D. Washington Medical Center 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

0 3 2009

SSIE

Ke.

P.O. Box 68760,

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State of Ma Registrar	aryland / Department of <i>Certificate o</i>		ygiene Reg. No. 2009	0273			
Physician /Medical	1. Decedent's Name (First, Middle, Last) Helen H. Koehler		2. Date of D Month		3. Time of Death			
Examiner	4a. Facility Name (If not institution, give street and number)  St A9 MC5 H65P  5. Social Security Number 6. Sex 7.4g	ital Balt	or Location of Death	4c. County of Death	ce (State or Forei			
Funeral Director	216.28.4408 1□ M 2 T F 8 Usual Residence of Decedent	Yrs. Months Day		Jay, Year) Country Baltin	more, Md			
e Marylan Ba-f show tiffed at	Md Baltimore	10c. City, Town or Location  Catonsville		10d	. Inside City Lim 1 ☐ Yes 2 ☐			
fler death with the Mar r items 23a or 28a-f sh ingr must be notified funeral Director	10e. Street and Number 500 Patleigh Rd.	10f. Zip Code 2122		10g. Citizen of What Country USA	?			
ours after de la la la la la la la la la la la la la	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☑ If Yes, Give Year or Dates:	If Yes, specify Co	Hispanic Origin? (Specify Yes or N ban, Mexican, Puerto Rican, etc.)  Specify:	14. Race - American Black, White, etc Specify: Wh1				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. In Department of Heath and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Eventient must be notified at once.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5)	16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti Homemaker	e during most of working ed)	16b. Kind of Business/Indus	stry			
Mental Harked oth arked oth atic event	17. Father's Name (First, Middle, Last)  Carl A. Horn		18. Mother's Name (First, Middle Arlene Dutr	,				
and 2 sho ealth and n 27 is m	19a. Informant's Name/Relationship (Type. Print) Susan Costello— Daughter	500 Patleigl	et and Number or Rural Route Num. n Rd. Catonsvill		ode)			
Pages 1 ment of H ant: if iter ury or oth	20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cametery, crematory or other p	2/02/2009	20c. Location - City or Town Catonsville,				
permit. Pag Departmen Important: any injury once.	21. Signature of Funeral Service Licensee	AOLOSO 22 Name and Add	ress of Facility -Ashton-Schwab-Wi ondson Ave.Catons	itzke Fun'l Hm sville,Md21228	of Cat			
cate be executed physician and the buriat-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as Due to (or	a consequence of):  a consequence of):  case years a consequence of):	any tract suffects	In O	pproximate terval Between			
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uires that n signed b	Part II. Other significant conditions contributing to death b	out not resulting in the underlying cause		tobacco use contribute to the o	cause of death			
ician: The law requir certificate has been s ector, page 2 should Be Completed	25. Was case referred to medical		perl 1 □ Yes	prior to comp formed? death? 2 No 1 Yes 2	y findings availa letion of cause □No			
To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1							
o the Hospital on thin 24 hours aft of the Funeral Di ompletely filled in Medical Cer	29a. Certifier  (Check only  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of	of my knowledge, death occurred at the of examination and/or investigation, in m	time, date and place, and due to th	own, State)  The cause(s) and manner as state, date and place, and due to the	ed. ne cause(s)			
To the To the comple	29b. Signature and trile of certifier	29c. Lice	58571	29d. Date signed (Month, Da				
4	30. Name and address of person who completed cause of d  Unin Tao MD 96  31. Date filed (Month, Day, Year) 32 registr	death (Item 23a) (Type, Print)  O CATON AVENUE  Par's Signature	58571 Baitimore	maryland	(			

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			For State	State of Ma		partment of F ertificate of		nental Hygie		02736
ĕ	Physici	an	1. Decedent's Name (First, Middle, La	st)	t		Dour	2. Date of Death Month	Day Th Yea	3. Time of Death
	/Medic	al	CHARLOHE 4a. Facility Name (If not institution, giv	re street and number)	Little		r Location of Death	JANUARY	4c. County of De	041345 ™ eath
			NOTHWEST MG 5. Spcial Security Number 6.5		ENTER (In yrs. last birthda)	RANDA If Under 1 Year	LISTOWN	8. Date of Birth	BALTIA	
	Funeral Director		411-36-6158	1 □ M 2 🔀 F	Yrs.	Months Days	Hours Min.	9-6-26	ar)	dirthplace (State or Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County	222.0-	10с. City, Town or I	ocation				10d. Inside City Limits
	the Ma 28a-f s notified	recto	MQ. BAITI	MURE		10f. Zip Gode	4.0	10g.	Citizen, of What (	1 ☐ Yes 2 ☐ No
	ath with s 23a or rust be	Funeral Director	9812 CIANTON	ed Ka.		21/3	33		4.5.1	4.
0000	ours after de ral', or items Examiner m	d by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ₩idowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1  Yes If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub:	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite; etc.
7-61717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	pation during most of work ALOC	ting 16b	Kind of Basines	SCHOOL
yland,	should be filed wind Mental Hygier imarked other th	To Be C	17. Father's Name (First, Middle, Last	mylor	10h Ma		MyRt	e (First, Middle, Maie	9115	
e, Ma	1 and 2 sho Health and em 27 is m	6 6 575	20a. Method of Disposition	herea"	9200	ling Address (Street)	00AGKE	al Route Number, Ci	Location - City	Alto, Ma.
altimor	permit. Pages Department of Important; If Its any Injury or o		Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Service Lice)	(y)	GARRE	matogy or other place of the pl	EST &	-6-09 C	WING	3 Mills, Md.
ם ם	permit. Departr Imports any Inji		Mynthia 4	Sun	te l	300 N.	CENTRA	TAVE.	BAHO!	NG. 5/302
	Physician	0 9	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin		LE UKE		or respiratory arrest,		Approximate Interval Between Onset and Death
<i>t</i>	/Medical Examiner			Due to (or as a	a consequence of):					
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
0,00,0	icate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequence of):	-				
00 00			IF FEMALE:	23c. If yes, outcome	of prognancy					
	t the death or by the atten- ached for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	/		23d. Date of d Month	elivery Day Year
cords, r	equires tha en signed I buld be det	by	Part II. Other significant conditions	ontributing to death bu	nt not resulting in the	underlying cause giv	en in Part I.			to the cause of death?  Probably 42 Unknown
מו חבכו	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was an autopsy performed	? death?	
1 0	hysiciar his certif I directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	er.	h <i>(Check only one)</i> ome 5 ☐ Residence	SEAS DOther (Sp	ONS HOSPICE
5	nding P th.: After t funera	tion:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		Wor	yat k? Yes 2 □ No	28d. Describe how in	njury occurred	
	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, s :. (Specify)	treet, factory, office		28f. Location (Street City or Town, St	and Number or i	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	ledical C	29a. Certifier (Check only one)	nysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the tir investigation, in my o	me, date and place, ppinion, death occur	and due to the cause red at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1416	1	29c. Licens		90000	Date signed (Mo	
	4		30 Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)	15931	76	BRUAR	1/3 H 2009 EMD 21209
10	₹ Sta	te	Dr. De bbie 31. Date filed (Month, Day, Year)	13 Urtor 32. Registra	1 2835 n's Signature	Smith	AVE #	203 BAL	Timore	E MD 21209
	Registr		FEB 0 3 2	009 Sene	u \$. 15	parket				

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

ician dical	ı	1. Decedent's Name (First, Midd Josephine Love	. ,						2. Date of D Month 30	Reg. No. Z	Yea	3.	Fime of Dea 9:25 1
niner		4a. Facility Name (If not institution Pear Tree As	sisted Li	ving			dena			Ann		undel	
al or		5. Social Security Number 213-12-6029  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Yea Months Day		24 Hrs. Min.	8. Date of B	s <sub>irth</sub> Sept 19, Year 192	22 9.1	Birthplace Country)	(State or Fo
ctor	1	10a. State 10b. County	Arundel		ity, Town or Locasadena								side City Li
al Director	1	10e. Street and Number 8001 Middleb	oury Dr.	Unit 3		10f. Zip Code 2112				10g. Citizer USA	n of What	Country?	
Other To Be Completed by Funeral Director		11. Marital Status  1 □ Never Married 2 □ Mar  3 □ ▼Widowed 4 □ Divorced	Armed F rried 1 ☐ Yes	2 ZNo iive	'	Vas Decedent o i Yes, specify Cu □Yes 2XN	iban, Mexicai	n, Puerto	pecify Yes or No Rican, etc.)		Black, W	merican Ind hite, etc. White	dian,
Completed	-		nt's Education est grade completed College	) (1-4or 5+)	1 (Give	lent's Usual Occ kind of work dor OO NOT use reti ier	e durina mos	st of work	ing		of Busine	ss/Industry	
To Be		<ol> <li>Father's Name (First, Middle, Philip Larroc</li> </ol>							e (First, Middl Fascia	le, Maiden Sui I <b>na</b>	rname)		
		19a. Informant's Name/Relations Joe Loverde,				g Address (Stre				ober, City or To		e, Zip Code	
	2	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (5			Place of Disport Cemetery, cren	sition (Name of patory or other p	lace)	I	Date -3-09	20c. Locat	tion - City		tate
-SCIDS-	ľ	21. Signature of Funeral Service			22	Name and Add	ress of Facili Funera	ty 1 Ho	ome. In	-		,	
al	-				eny	dre	hon					Inter Ons	et and Deat
ical Examiner		Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	(or as a consection of or a consection of or a consection of or as a consection of or a consection or a consection of or a consection of or a co	em querce of):	dra en fi	tion						7 Q
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09-00851

Amend Item #1 as noted per ME 0888 2/9/09 TT Please Type or Print in Black Indelible Mk. Ensure All Copies Are Legible.

		1. Decedent's Name (First, Middle,Last)  DAWAYNE WILL!	AM	LAWREN	'CE	2. Date of Death Month January 28	Day Year 3, 2009	2314 hrs
		DAWAYNE WILLI 4a. Facility Name (if not institution, give street and	i number)	4b. City,	Town, or Location of De		4c. County of Deat	th
		4900 Blk. of Aberdeen Avenue	7 424 (1 )		more	ILIco 10 Data of Disas	h(MM/DD/YYYY) 9. Bi	ithplace (State or
eral tor	c	5. Social Security Number 6. Sex 1 1 1 M 2	7. Age (In yrs. la	Yrs.		Min. 01/31/	Forei	
any	_	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limi
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Z8a-f show I at once.		10e. Street and Number	L		p Code		g. Citizen of What Cou	untry?
ا الله		1647 RAMBLEWOOD	D ROAD	D	21239		U.S.A.	
be no			Decedent Ever in U.S d Forces?		ent of Hispanic Origin?		14. Race - Ame White, etc.	erican Indian, Black,
or it	Ē	1 Ye	es 2 No				_	2. 1511
	<u>ā</u>	3 Widowed 4 Divorced If Yes, Give or Dates:			2 No specify:		Specify: 15	
Exar	ا <u>چ</u>	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College	grade completed) e (1-4 or 5+)		l Occupation (Give kind orking life, DO NOT use		16b. Kind of Business	smidustry
than	be	10 <sup>Trl</sup> GRADE	(1-7 UI UT)	.371	DENT		NA	
other than the Medical	Completed	17. Father's Name (First, Middle, Last)		0,0		vame (First, Middle, N	/	
		LARRY LAWK	ENCE	SR.	IRI	S D.	WILL	IAMS
	ို	19a. Informant's Name/Relationship (Type, Print )		19b. Mailing Addres	ss (Street and Number	r or Rural Route Num	nber, City or Town, Sta	te, Zip Code)
tem 27 is n traumatic		IRIS WILLIAMS LO. 20a. Method of Disposition	OTHER)		MBIEWOO		9LTIMORE,	mD 2123
other trauma		20a. Method of Disposition  1 Surial 2 Cremation 3 Remov	20b. F	Place of Disposition (Na crematory or other place		Date	20c. Location - City of	or Town, State
r oth		4 Donation 5 Other Specify:		T. ZION CE		2/04/2009	LANSDOW	NIE, MARYUA
Important: injury or oth	t	21 Signature of Funeral Service Licensee	111.					
Ē.Ē	_	23a. Part I. Enter the disease, or complications the	Milliam	21401	d Address of Facility  H. BROD  U.FULTON	AVE, C	ALTIMORE	Approximate Inter
ical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Gunsho	t Wound of Hea	ad .				Between Onset a Death
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	J	Sequentially list conditions, b						
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	xaminer	if any, leading to immediate Due to (or cause. Enter Underlying Cause	as a consequence of	of):				
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Jan. 29 ay **Physician** /Medical city, Town, or Location of Death Examiner Baltimore atonsville yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 1 M 2□ F Months Hours Director 10c. City, Town or Location State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the "Modical Expirient", ust by ruitflied 31 once. 1 Øes 2 □ No tonsville Completed by Funeral Director 10g. Citizen of What Country? ILLSA 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NPT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aborer Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ en 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition cemetery, cremator Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA SCU /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ After this certificate has been si funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed? 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ) MA BUSINESS CENTER DRIVE REISTERSTOWN MD 21136

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FFR 0 3 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:30 <sup>а м</sup> Betty Joan Lear 31, 2009 January /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 1415 Reynolds Street **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 14, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1932 218-28-2177 1 M 2 TF 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Evantination in the notified at any Injury or other traumatic event, I'm Madical Evantination in the notified at any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1⊠Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 1415 Reynolds Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 White 1 □Yes 2 X No If Yes, Give Year or Dates: Specify: ģ Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Brown Marie M. McOuade ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Pendleton / Daughter 1544 Latrobe Park Terrace, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 2/3/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee Victor Doda 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cel ancer of **Physician** as disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): physician s the burial Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2X No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ()i)ease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 LUnknown Completed Cay di rinjul Ma. Was an autopsy osclerotic 24b. Were autopsy findings available prior to completion of cause of death? nisense performed 2**X** No 2 🗆 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home X Residence 6 Other (Specify) 2€ No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DDA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signat e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 026203 address of person who completed cause of death (Item 23a) (Type, Print) Light St. Baltimore Va 1001 3 110 mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State falled Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 02741 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1/30/2009 04:12 AM Donald James Latham, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/04/1946 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 2 M 2 □ F 62 266-78-1124 WV **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Itw Medical Examinat Funt be notified at 10a. State 1 ☐ Yes 2 No Director MD Severna Park Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 512 St. Martins Lane 21146 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Contractor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty M. McNear Charles W. Latham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21146 P.O. Box 568 Severna Park, MD Mrs. Betty Reynolds / sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2009 Brooklyn Park, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 AC01357 ancen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach jne. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Physician/Medical as the t IF FEMALE for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) \$\infty O \tag{\sqrt{\chi}}\$ 1 Tes 2 **1** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

State

DHMH 17 Rev 1/2001

Medical

Registrar

29a. Certifier

29b. Signature

Flavio Kruter, MD 31. Date filed (Month, Day, Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ROSSRUMOS Dr. Ste 340 OWINGSMILLS MO 21117-

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 31, 2009 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7907 Runnymeade Drive Frederick Frederick 8. Date of Birth (Month, Day, Year) 11/15/1928 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Min. Hours 80 1 **3** M 2 □ F Director 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County show d other than "natural", or items 23a or 28a-f show event, the Madical Exeminar must be notified at MD Frederick Frederick 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7907 Runnymeade Drive 21701 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🔀 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo White Ş Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event an once. grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+ Scientific Research Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Natale Luscri Emma Depizzol ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Luscri / Wife 7907 Runnymeade Drive, Frederick, MD 21701 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 € Burial 2 ☐ Cremation 3 ☐ Removal from State 2/5/2009 Calvary Cemetery Pittsburgh, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral 21. Signature of Funeral Service Licensee Dorota Marshall Home Inc. 1501 East Fort Avenue, Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): month disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month signed by the at d be detached for 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Ş Q 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2**X** No 1 ☐ Yes 2 No I or Attending Physiclan: after death. ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check onl one) and manner stated 29b. Signature and title of certifier

State Registrar houson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ernest Theodore M	1-	For State	tate of Ma	ryland /		ent of He		Mental Hy		. No. 20	09	0274
Physician/		egistrar . Decedent's Name (First, Mid						012	2. Date of Death		3. Tim	e of Death
Medical Examine	T A	Ernest 7			Moor	·e			January 30,			12 hrs
	4	<ul> <li>Facility Name (if not institut</li> <li>University Hospital</li> </ul>	ion, give street ar	nd number)			ty, Town, or Lo I <b>ltimore</b>	ocation of Death		4c. County of De	ath	
-	5	Social Security Number	6. Sex	7 Age	(In yrs. last bi		Under 1 Year	If Under 24Hrs.	8 Date of Birth	(MM/DD/YYYY) 9.	Birthplace	(State or
Funeral Director		217-90-5276			44	М	onths Days	Hours Min.	8-14	(MM/DD/YYYY) 9. Fo	eign 4a Country)	ryland
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the Maryland a or 28a-f sh iifred at once	1	0e. Street and Number				10f	. Zip Code		100	g. Citizen of What C	A	
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er death w , or items r must be Funer	5 .		ivorced If Yes, Given		<b>∠</b> No	1 Ves	2* No	snecify:		Specify: 13	10.04	
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72 hor		Elementary/Secondary (0-12	2) Colle	ege (1-4 or 5	j+)	-	_	DO NOT use reti		1	,	
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2121 Ild be fil Mental F wurked event,		Ernest Moo 9a. Informant's Name/Relation	12 Jr	1)	1	9h. Mailing Add	ress (Street		Cros	per, City or Town, S	tate, Zip C	ode)
AD 2 show and 3 zz is a mratic	-	Frances Moo.		C		_	٠.			b led. 20c. Location - Cit		
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Baltimore, MD 21215-0036  Demnit Pages I and 2 should be filed within 72 hours after begarnen of Urleath and Mental Hygiera Hoportani: If tiem 27 is marked other than "natural", injury or other traumatic event, the Modical Examiner To Be Completed by 1	'	Burial 2 Cremati Donation 5 Other		oval from Sta	Ark.	his Un	n Park	56	6 7219	Buth	led	
Baltime permit Pag Department Important: injury or ot	2	1. Signature of Funeral Service			Alpu	22 Name	and Address	of Facility	is Fane	ral Serv	ice	04
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Physician	2	a. Fart I. Enter the disease, failure. List only one caus	or complications se on each line.	t er caused	the death. Do	not enter the m	ode of dying, s	such as cardiac o	or respiratory arres	st, shock, or heart	App	ween Onset and
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ision of Vital Records, P.O. Box 68760. Attending Physician: The law requires that the death certificate radesh.  retoen. After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the because from To Re Commissed by Physician/Metration: To Re Commissed by Physician/Metration:	2 ادە	25. Was case referred to medi examiner?						of Death (Check	only one)			
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Division of V  To the Hospital or Attending Physicaling 24 boars after death.  To the Funeral Director: After this completely filled in by the funeral director.	300		xaminer: On the							and place, and due		e(s)
F F S E	<u>₹</u> 2	29b. Signature and title of cert					29c. License	number		29d. Date signed	(Month, De	ıy, Year)
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B	1	30. Name and address of pers					) = 14i *	MD 04004				
9			tant Medical			nn Street, I	saitimore, N	VID 21201				
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			101	partment of Health and I pertificate of Death	Mental Hygie	ne 2009 02744
	Physicia		1. Decedent's Name (First, Middle, Last)  Carmen G. McFarland		2. Date of Death Month January 3	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)  105 Gothard Road	4b. City, Town, or Location of Death	<del></del>	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 25 83 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye. 6/25/192	9. Birthplace (State or Foreign Country) 5 Balt., Maryland
and	MO T		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
e Maryl	la-f sho	ctor	Maryland Baltimore Luthery	ville		1 □Yes ¾∑No
th with th	23a or 28 ust be no	Funeral Director	10e. Street and Number 105 Gothard Road	10f. Zip Code 21093	Un Un	citizen of What Country? ited States f America
<b>3-0036</b> 72 hours after dea	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be notified at once.	ğ	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Single Yes, specify Cuban, Mexican, Puerton 1 □ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
<b>1.6.1.3-U</b> within 72 ho	iene. • than "natur he Medien	Completed	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation ve kind of work done during most of work DO NOT use retired) Ability Case Examin	king	. Kind of Business/Industry Social Security Administration
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iryia	nd Men marke matic	은	Richard E. Croke  19a. Informant's Name/Relationship (Type. Print)  19b. Ma	iling Address (Street and Number or Ru	3 A. Meyd	ity or Town State Zin Code)
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nore	ent of H it: If iter y or oth		20a. Method of Disposition  1₺ Burial 2 □ Cremation 3 □ Removal from State  4□ Donation 5□ Other (Specify)		ruary	Location - City or Town, State
baltimor permit. Pages	Departme Importar any injur once.					Monium, Maryland &Cremation Ctr.,P.A. Maryland 21093
Ex	ysician Medical taminer the prival-transit	dical Examiner	23a. Parf1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each limit	enter the mode of dying, such as cardiac	c or respiratory arrest,	Approximate Interval Between Onset and Death
I RECORDS, P.O. BOX 08/00, The law requires that the death certificate be executed	s been signed by the attending ph should be detached for use as th	Physician/Med		B		23d. Date of delivery Month Day Year
uires that	signed b Id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
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VITall ysician: ⊺	s certifi director	o Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat	Othor	ath (Check only one)	e 6 □Other (Specify)
DIVISION OF VICA To the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	27. Manner of Death    12   Natural   5   Pending   2   Accident   28b. Time	of 28c. Injury at	28d. Describe how in	
DIVIS	s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S.	t and Number or Rural Route Number, tate)
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Tott	To the company of the	M	29b. Signature and title of certifier ( and , M)	29c. License number  D 309 29	29d.	Date signed (Month, Day, Year)
_	10		30 Name and address of person who completed cause of death (Item 23a) (Typ	e. Print) Charles ST	, #205	BAITMEN, MD Z1204
	Sta Registr		31. Date filed (Month, Day, Year)  See 32, Registrar's Signature  FEB 0 3 2009	barked	/	/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ye ar MELOY **Physician** ERTIE 2009 JANUARY 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-24-1264 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at 1XYes 2 No BALTIMORE Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 906 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23: any Injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Yes, Give Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL Balto. City Dept. of Aging 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TAYLOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON MOCOY (DAUGHTER) 906 CALWELL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARK 02/03/2009 BALTIMORE, MARYLAND KING MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

505EPH H. BROWN JR. FUNERAL HOME
2140 N. FULTON AVE, BALTIMURE, MD 21217 21. Signature of Funeral Service Licensee reliano 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNUEMONIA Physician BILATERAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ARTERIOSCLEROTIC Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Completed by Physician/Medical signed by the attending p IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown からびそろど REBRO-VASCULAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 □ No DIABETE 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

2000 W. BAZTIMORE ST. 31. Date ffled (Month, Day, Year) FEB 0 3 2009

29b. Signature and title of certifier

and manner stated.

PATEL.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SELONES HOSPITAL

29c. License number

223300

29d. Date signed (Month, Day, Year)

JANNARY 27 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				epartment of Health and M Certificate of Death		ene g. No. 2009	0 0 2 7 1.4
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
d	/Medi Exami		Harry C. Manger, Jr.  4a. Facility Name (If not institution, give street and number)  Stella Maris	4b. City, Town, or Location of Death	Feb. 1,	2009  4c. County of Death Balti	
	Funeral Director		5. Social Security Number 212-07-7782 6. Sex Yrs Usual Residence of Decedent 7. Age (In yrs. last birtho	lay) If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 19,	(ear) 9. Birth	nplace (State or Foreign intry) Yland
	he Maryland 28e-f show	Director	10a. State 10b. County 10c. City, Town o	Timonium			10d. Inside City Limits 1 □ Yes 2XXNo
	h with t		10e. Street and Number 2525 Pot Spring Road	10f. Zip Code 21093	10g	p. Citizen of What Cou USA	intry?
0036	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, it a Medical Evaninar must be notified at once.	d by Funeral		3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F  1 □ Yes ※XNo Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
Maryland 21215-0036	od within 72 h /giene. er than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 2	ecedent's Usual Occupation ive kind of work done during most of workin e. DO NOT use retired)  Manager	16	b. Kind of Business/Ir	elephone
ryland	2 should be file and Mental Hy Is marked oth aumatic event	To Be (	17. Father's Name (First, Middle, Last) Harry C. Manger, Sr.	18. Mother's Name	Esther	Kennard	•
re, Mar	1 and 2 sh Health and tem 27 Is n		Deborah Carski/Daughter 514	Hampton Lane Towso	on, Mary	land 21286	
Baltimore,	mit, Pages partment of ortant: If if Injury or e		1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State	Valley Mem. Grd. 2/4	4/09 Tin	nonium, Ma	rvland
B	Dep mp eny eny		Muchael of Ruch fr.	22. Name and Address of Facility Ruck 1050 York Road Tow	k lowson wson, Mar	Funeral Heryland 212	ome, Inc. 04
8760,	Physician / Medical Examiner  bulyaician and street per executed street transit street private street per executed street per	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last  CHRONIC OBSTRUCT  Due to (or as a consequence of):  Due to (or as a consequence of):  C	IVE PULMONARY DISEAS	E		Onset and Death
P.O. Box 687	The law requires that the death certificate be executed atte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical		B ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
Records, I	w requires that been signed should be de-	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th	
Vital Rec	<b>hyslcian:</b> The law r his certificate has be I director, page 2 sh	e Completed by	25. Was case referred to medical		24a. Was an autopsy performed 1 ☐ Yes 2X	? prior to cor death?	psy findings available inpletion of cause of
Division of Vi		면 일	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpat  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  Hospital: 1 Inpatient 2 ER/Outpat  28a. Date of Injury (Month, Day, Year)  28b. Time Injury	of 28c. Injury at 28		e 6 N Other (Specify	HOSPICE
Divi	pital or Attendurs after death aral Director: , illed in by the f	Certifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St		
	ple ple	edic	29a. Certifier  (Check only one)  X Nurse Practitatomer stated.  1 □ Certifying Physician: To the best of my knowledge, de 2 □ Medical Examiner: On the basis of examination and/or 2 Nurse Practitatomer stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred  29c. License number	l at the time, date a	and place, and due to	the cause(s)
D	- SF S		30. Name and/address of person who completed cause of death (Item 23a) (Type	B14979Z	29d. I	Date signed (Month, L	Jay, Year)
	IUT		JACKIE JONES, CRNP 2300 DULANEY VA		MD 21093	3	
	Stat Registra		FEB 0 3 2009 Registrar's Signature				

DHMH 17 Rev 1/2001

FEBRUARY 1, 2009 2:25 p.m.

HARRY MANGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Bernadette D. Metz February 2009 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 Smeton Place #1205 Towson Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 12/1/1914 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Numbe 216-03-4750 **Funeral** 1 □ M 2 🖫 F 94 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Baltimore Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1 Smeton Place #1205 21204 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2XXNo altimore, Maryland 21215-0036 Specify 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura Miller Joel H. Drummond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Smeton Place #1205 Towson, Maryland 21204 Joseph F. Metz, III / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 2/6/2009 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zheimer's Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ②No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was ar certificate has t irector, page 2 s autopsy performa Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes ≥ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To 5 Residence 6 Other (Specify) this hours after death.

Ineral Director; After this y filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

0

State

30. Name and address of person who completed

OUL

Grenze

6569 W. Ch .- les St. #600 Belto ML 21204

se of death (Item 23a) (Type, Print)

MID.

Registrar's Signature

Amend 19b per FH g888 2/6/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:00PM JANUARY W. Melvin Alan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Year) **Funeral** Min. April 25,1939 Maryland 69 212-36-3947 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f shovevent, the Modical Examinar must be notified at 1 ☐ Yes 2 XNo Glen Burnie Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 941 Sunnybrook Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: <u></u> White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than any injury or other traumatic event, Ital In once. Supervisor Northrop Grumman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Melvin Beverly Edwin ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sunnybrook
941 Sunntbrook Drive Glen Burnie, Maryland 21060 19a. Informant's Name/Relationship (Type. Print) Carole A. Melvin (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/03/09 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCariy-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by NEUMONIA CMMUNITY 1 No Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performer 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0006121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL GLENBURNIE HARVINDER 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 31, 2009 7:45P JOSEPH KEVIN MUELLER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Towson Gilchrist Hospice Care | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 02/19/1931 Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6 Sav 7. Age (In vrs. last birthday Months **X** M 2 □ F 218-30-6962 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2√2 No Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21212 USA 43 Parliament Court 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No KORFA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11 Marital Status 1 Never Married XX Married 1 □Yes 2XXNo If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Gerard Mueller Mary Frances Mackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 43 Parliament Court Baltimore, Maryland 21212 Maris Stella Mueller Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus 02/05/2009 Baltimore, Maryland 4/□ Donation 5 □ Other (Specify) 22. Name and Address of Faci Mitchell-Wiedefeld Funeral Home Inc Signature of Fun A Lery ce Livensee 6500 York Road Baltimore, Maryland 21212 Mus ! 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WEEKS UN9 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

\$

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

à

Completed

? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be redified at

Department of Health and Mental Hygient Important: If item 27 is marked other that any Injury or other traumatic event. Ithe 2006.

72 hours after

altimore, Maryland 21215-0036

burial-transit and attending physician for use as the buria signed by the a director, page 2 should certificate After this funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

HYPERALDOSTERONISM 26. Place of Death (Check only one)

Hospital: 1  $\square$  Inpatient 2  $\square$  ER/Outpatient 3  $\square$  DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

5 ☐ Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HOSPICE 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number D64395 29d. Date signed (Month, Day, Year) FEBRUARY 1,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

BALTIMORE, MD 21204 6565 N CHAPLES ST, 84172-209 BOB ERMAN. MO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

24 hours after death. Funeral Director; A

To the within 2

filled in by

completely

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 3:30 Рм 1600 January 29 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1523 Filbert Street Baltimore N/A 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 21, 1924 9. Birthplace (State or Foreign Country) Kentucky Min 1 □ M 2 🖾 F Months Days Hours 405-24-4708 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Maryland N/A **Baltimore** N☐Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1523 Filbert St.. 21226 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc 1 ∐Yes 2 [No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City School System Food Service in Cafeteria 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathaniel Hop Flanary Susan Shoop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony W. Monka (Son) 1523 Filbert St., Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 2/2/2009 Baltimore, Maryland 4 ☐ Donation 5, ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ears 80 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗌 No 3 ☐ Probably 4 dnknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760,

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 24 hours after death. 9 Funeral Director; After this certificate has been signed by the attending physician and burial-transit attending physician cate has been signated by page 2 should b

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is item 1. It is in it in the continued once.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0036

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Certification: To

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> State Registrar

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31. Date filed (Month, Day,

29b. Signature and title of certifie

3 Suicide

29a Certifier

4 Homicide

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month JANUARY 2009 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Edica DUR If Under 24 NTER 8. Date of Birth (Month, Day, Year) March 27,1940 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Months Days Hours Min. 1 □ M 2 1 F 216-34-7997 68 Yrs. MD Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2♥ No MD Anne Arundel Glen Burnie, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Wellham Avenue N.W. 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Blake Anna Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Wellham Avenue N.W. Glen Burnie, MD 21061 Mr. Charles Mathews/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/31/2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton 21. Signature of Juneral Service Licensee Funeral & Cremation Services P.A. 1 2nd Ave. SW Glen Burnie, MD21061 101220 23a. Part 1. En at the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OSIS medi? disease or condition resulting in death) Due to (o as a consequence of): Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last - horacic Compiession Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform murhid Opes My , respirating 1 □ Yes 27 2 No 26. Place of Death (Check only one) examiner? Hospital:

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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altimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical

Be Completed by

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical

2 No 1∐ Yes 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) And manner stated. 29b. Signature and the of certifier mo

29c. License number n 00aa 483 29d. Date signed (Month, Day, Year)

30. Name and address of person who compl ed cause of death (Item 23a) (Type, Print)

Qc obs 31. Date filed (Month, Day, Year)

Mn 32. Pegistrar's Signature Dr. Glan Burnu,

State Registrar

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within 24 hours a
To the Funeral D Hospital

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28b. Time of

228-36-4540 Usual Residence of Decedent Director Maryland 10e. Street and Number 7548 Old Telegraph Road Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. 17. Father's Name (First, Middle, Last) Be George Η. Landrum Maud Ray Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 N. Edgewood St. Mr. Michael R. McMurtrie / Son Arlington, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2009 Glen Haven Mem. Park Glen Burnie, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave. SW Glen Burnie, MD 21061

Physician /Medical Examiner

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Physician/Medical Examiner

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Certification: To

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**Physician** 

/Medical

**Examiner** 

Funeral

Director

if than "natural", or items 23a or 28a-f show

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Pages 1

or Attending Physician: The law requires that the death certificate be executed

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Vital

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Division

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Baltimore, Maryland 21215-0036 Thri

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMON: A Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown ☐Yes 2☐No

Hospital:

3 🗆 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Day

Year

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ 1√10 1 ☐ Yes

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ 1√0 27. Manner of Death 5 Pending investigation 1 Natural

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

and manner stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a, Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

26. Place of Death (Check only one)

29b. Signature and title of certifie

6 Could not be

29c. License number 20055703

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Berhane 301 Hospital Drive Glen Burnie, MD 21061

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Gertrude McGarr 11:55 30, 2009 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 93 Yrs. Social Security Number Date of Birth (Month, Day. **Funeral** 430-30-8851 Months Days Hours Min. 1 □ M 2 🕅 F 11/7/1915 AR Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 2 should be filed within 72 hours after death with the Maryla and Mental Hyglene.

Is marked other than "natural", or items 23a or 28a-f show raumatic event, if a Mexical Examiner must be notified at MD Baltimore Timonium 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 2300 Dulaney Valley Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2**X** No Specify: Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail Store 18. Mother's Name (First, Middle, Maiden Surname)
Maggie Bell Maryland 17. Father's Name (First, Middle, Last)
Thomas Ozment Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau 6 Stapleton Court #102, Timonium, MD 21093 Carole Nicholson / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 XBurial 2 ☐ Cremation 3 X Removal from State Oakland Cemetery Monticello, AR 2/4/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dorota Marshall Charles L. Stevens Funeral Home Inc.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician menti /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 🖾 (No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation al or Attendin s after death. al Director: A ed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Division of Vital Records. McGARR

30,

JANUARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 QULANEY VALLEY ROAD TIMONIUM 21093 MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 2 2009 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 2009 8:25 A M DOROTHY MAGAZINER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE NORTH OAKS HEALTH CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🖫 F 156-03-2704 89 01/22/1920 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2/☐ No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 725 MT. WILSON LANE 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: WHITE Specify: 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **ESTHER** ROSENBERG HARRY COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAY MAGAZINER / SON 1430 IVY HILL ROAD COCKEYSVILLE, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR PARK CEMETERY 02/04/2009 EMERSON, NJ 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licenses INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐ Unknown 9 Unknown

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

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	Medical Certification: To Be Completed by Physician/Medical Examiner
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art II. Other significant conditions o	contributing to death but not res	ulting in the underlying	cause given in Part I.		ise contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
5. Was case referred to medical			26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 之☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □ D	OA Other: 4 Nursing H	lome 5 ☐ Residence	ASSISTED ASSISTED
7. Manner of Death  1 → Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, facto	ry, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
	nysician: To the best of my knominer: On the basis of examination and manner stated.				and manner as stated. If place, and due to the cause(s)
9b. Signature and title of certifier		29	9c. License number	29d. Da	te signed (Month, Day, Year)
Pan mili	r MD		DA7683	i	13/09

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Man

32. Registrar's Signature

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Kanney 31. Date fijled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ORIS JANUARY 31, 2009 11:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 134 ROYALTY CIRCLE OWINGS MILLS BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 02/01/1940 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1**X**□ M 2□ F 68 AZERBAIJAN 029-72-0059 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the "Medical Evan in the unit be notified at 28a-f show Director 1 ☐ Yes 2 🜠 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 ROYALTY CIRCLE 21117 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 💥 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2**Y**□No Specify: ð Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) **OWNER** TRANSPORTATION es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARYAKHIN MARY BR00K ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LENA MARYAKHIN / WIFE 134 ROYALTY CIRCLE OWINGS MILLS, MD 21117 permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW CEM. 02/02/2009 REISTERSTOWN, MD 4 Donation 5 DOther (Specify) 21. Sig ture f Funeral Service Live 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 24 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): physician the burial P.O. Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2. ₩o 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58037

Registrar

State

200 EAST 33 RS ST. , # 460; BALTIMORE, MB 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date\_filed\_(Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 11:45P <sup>™</sup> 31. JANUARY MEYEROV **FENYA** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner OWINGS MILLS BALTIMORE 1121 SILENTGLADE ROAD Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2**X**□ F 86 07/06/1922 UKRAINE 217-25-5446 Director Usual Residence of Decedent 10d, Inside City Limits should be filed within 72 hours after death with the Maryland und Mental Hygiene. 10c. City, Town or Location 10a State The marked of the than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinan must be notified at 1 ☐ Yes X ☐ No OWINGS MILLS BALTIMORE Director MD 10g. Citizen of What Country? 10e. Street and Number 21117 USA 1121 SILENTGLADE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE þ 3 ¥ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **PHARMACIST** PHARMACEUTICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **GDALYA ALEXANDER** SHIFRIN SURKA SOKOL ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. 1121 SILENTGLADE ROAD OWINGS MILLS, MD 21117 DINA ANOKHIN / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 02/02/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by ALZHEIMER'S, DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No After this certification funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1∐Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No ie Funeral Director: A pletely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier npletely i (Check only and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier whend o Bay, ND Dockobo4 horge d 2/1/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard A. Berg, AD; Suite 450; 10755 Fell Road, Lutherville And 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 0 2 2009 acto

Division of Vital Records, P.O. Box 68760,

this certificate has To the Hospital or Attending Physicians, within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

1 ✔ Yes

27. Manner of Death

Natural

Accident

Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Patricia Aronica-Pollak MD

EER 02

4 V Homicide

29a. Certifier 1

State

Certification:

Medical

2

3

Registrar DHMH 17 Rev 1/2001

OCME 2006

Assistant Medical Examiner

Inpatient 2

(Specify) Local Street

28a. Date of Injury

Jan 26, 2009

and manner stated

Pending

Investigation

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

OCME

Registrar's Signature

ER/Outpatient 3

0402 hrs

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28b. Time of Injury

28c. Injury at Work?

29c. License number O.C.M.E.

1 ✓ Yes 2 No

111 Penn Street, Baltimore, MD 21201

28d. Describe how injury occurred

or Town, State) 200 N. Bond Street, Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City

January 26, 2009

29d. Date signed (Month, Day, Year)

Subject shot

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	-		Registrar  1. Decedent's Name (First, Middle, La		Cerun	cate or	Dealli	2. Date of De	Reg. No	· 2 U U	3. Time of Death	) (
	Physici /Medi		Mary Elizabet	th Norris				Janua:	rv 3	<sup>Yea</sup> 1, 2009		M
and the same	Examir		4a. Facility Name (If not institution, giv	ve street and number)	4b.	City, Town, o	r Location of Death		-	c. County of De		
New Y			411 Carrollwood I 5. Social Security Number 6. S			liddle Jnder 1 Year	River If Under 24 Hrs.	0 0-440:		altimor	e irthplace (State or Fore	
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	h with 23a or	al Di	411 Carrollwood I	Road		21220			II :	S. A.		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exar-itmr must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)			nerican Indian,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		es 2∏No				Specify:		
Maryland 21215-0036	2 hour	ted	15. Decedent's Ed	ducation 16a.		Usual Occup			16b. k	Kind of Busines	White s/Industry	
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121	iiled wi Hygier ther th		12 17. Father's Name (First, Middle, Last		memak	er	40 Markada Nasa	(Final Beindella		n Home		_
anc	d be fi ental H ced ot c ever	Be C		)			18. Mother's Name			n Surname)		
ary	and Me is mark	은	George Betz  19a. Informant's Name/Relationship (	(Type. Print) 19b.	Mailing Ad	dress (Street	Evelyn and Number or Run	MCCa al Route Numb		or Town, State	, Zip Code)	_
ž,	and 2 ealth a n 27 is		Richard William B	Norris (Husband)	411 C	arroll	wood Road	Midd	le_R	iver, M	21220 aryland	)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mydical Exp. instrinuts be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of cemeters	Disposition cremator	(Name of y or other plac	ce)	Date	20c. L	ocation - City o	or Town, State	
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-	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	Com	6					Interval Between Onset and Death	1
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	atteneration	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death		opic pregnanc	У			23d. Date of d Month	lelivery Day Year	
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Division of Vital Records,	ding Phys h. After this funeral dir	Certification: To	27. Manner of Death	28a. Date of Injury 28b. Ti		28c. Injur	4 - Nursing Hu	28d. Describe			респу)	
sior	endin eath. or: Af	atio	1 X Natural 5 Pending 2 Accident investigation	n	N		Yes 2 □ No					
Ξ	or Att	rtific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		n, street, f	actory, office		28f. Location City or To			Rural Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	o le	29a. Certifier 1 🕅 Certifying Pt	nysician: To the best of my knowledge,	death occ	urred at the ti	me, date and place	and due to the	e cause/	s) and manner	as stated	
	n 24 h	edical	23	miner: On the basis of examination and manner stated.								
	To the He within 24 To the Fu	Me	29b. Signature and title of certifier	1,117		29c. Licens			29d. Da	ate signed (Mo	nth, Day, Year)	_
	4		I With Chil	itifull m		12	4356		fel	nug	2, 2009	
5			30. Name and address of person who	completed cause of death (Item 23a) (7	ype, Print	coult.	4356 Square	1		0		
	Sta	te	31. Date filed (Month, Day, Year)	37. Registrar's Signature	13 1	MAINHIM	Square	DV.				
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pay 31 2609 1235AM ANUARY The1ma O'Donnell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WARHINGTON MEDICAL CENTER BURNE CLEM 8. Date of Birth (Month, Day, Year) If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 1 □ M 2 Ϊ F 94 July 7. 212-22-4730 1914 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland | Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3800 Eighth Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk City of Baltimore N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Howard Georgia Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis P. O'Donnell (Son) 11236 Bellflower Lane Huntley, II 60142 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Pk. 02/03/09 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 Fast Patapsco Avenue Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be 2

Funeral

**Director** 

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

burial-transit physician ed by the a detached f signed k certificate has been si rector, page 2 should funeral director, To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

disease or condition resulting in death)	a CARMOL	ENICI S	shock			IMREK
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of	b. Due to (or as a consect Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (or according Due to (o	quence of):	shock RAIMI	RE		1 YEAR
iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	ai death 3 □Ectopic			23d. Date of de Month	l blivery Day Year
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		···		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical	/		26. Place of De	eath (Check only one)		
examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatient 3 ☐ I	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Spe	ecify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Fi te)	lural Route Number,
1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined  29a. Certifier  (Check only one)  29h Signature and titleof certifier	hysician: To the best of my knominer: On the basis of examinated and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a nd place, and du	s stated. le to the cause(s)
29h Signature and title of certifier		2	9c. License number	29d D	ate signed (Mor	th Day Year)

29d, Date signed (Month, Dav. Year)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ame and address of person who complet

DHMH 17 Rev 1/2001

Mi)

d cause of death (Item 23a) (Type, Prigt)

Hos

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of I	Marylan		artment of H			giene 009	02760
				Hegistrar     Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
		Physicia		James Garfield Parris					Jahuax	4 29 2°	09 13:25PM
		/Medic Examin	_	4a. Facility Name (If not institution, give street and number	er)		4b. City, Town, or	Location of Dea		4c. County of D	Death
		Examin	31	Sinai Hospital of	Baller	more	Baltin	more t	ily_		
		Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. I			If Under 24 Hi Hours Mi		h y, <i>Year</i> ) 9.	Birthplace (State or Foreign Country)
		Director		220-38-6797 XCM 2 F	68	Yrs.			07/18/		ennessee
	P	> ::==1	-	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Le	ocation				10d. Inside City Limits
	aryla	shov	5	9 11	100.00.						1 ☐ Yes 2 ☐ <b>X</b> No
	death with the Maryland	- 8a-1	Director	MD Carroll  10e. Street and Number		r I	nksburg			10g. Citizen of Wha	t Country?
	with t	Le C	吉					1048		INited	l States
2	eath	18 23	by Funeral	2645 Sunset Lane  11. Marital Status 12. Was Decede	nt Ever in U.	.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or No		American Indian,
3	9	Item	S	1 Never Married 2 Married 1 Yes 2	s?				erto Rican, etc.)		White, etc.
	<b>336</b> Irs af	o','e	þ	3 XWidowed 4 Divorced Year or Date			1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
Jaines	1215-0036 within 72 hours after	etur.	ted	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occup	ation during most of w	vorkina	16b. Kind of Busin	ess/Industry
Ž	215 hin 7	. L	ed.	Elementary/Secondary (0-12) College (1-4	or 5+)	life.	DO NOT use retired	d)		<b>.</b>	G
13	27	il Hygiene. other thar vent, Ire M	Completed	8		Mai	ntenance	40 14-15-4-1	lama /First Middle	Maiden Sumame)	Government
13	DG #	d oth	Be	17. Father's Name (First, Middle, Last)							
_	aryla should b	Mental arked o	P_	James Howard Parris					ie Mae Ha	er, City or Town, Sta	to Zin Codel
5	ar 2 sh	is my		19a. Informant's Name/Relationship (Type, Print)	- t \						
arris		Health and Mental Hygiene. item 27 is marked other than "neturer", or Items 23s or 28s-f show titem 27 is marked other than "neturer", or Item 21 is notified at other traumatic event, the Medical Examinar must be notified at		Stella M. Richardson (Signal Method of Disposition		_			Date	Maryland 20c. Location - Cit	
20	S	0 -		1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from St	ate		osition (Name of ematory or other place		100 10000		
	tim	Department of Important: If any injury or once.		* 4 □ Denation 5 □ Other (Specify)  21. signature of Funeral Service Licensee	MO	Control of the Control	Memorial Name and Addre	4 40 100			Maryland
as	Bal	Depa Impo any it		21. Ignatur of Pulletal Service Licensee				h		neral Hon	
3				23a. Part1. Enter the disease, or complications that cat shock, or heart failure. List only one cause on each	ised the deat	th. Do not er	ter the mode of dyir	ng, such as card	iac or respiratory a	rrest,	aryland 21229 Approximate
1				shock, or heart failure. List only one cause on each Immediate Cause (Final	th line.						Interval Between Onset and Death
3		nysician Medical		disease or condition a.	as a conseq	he 1	ymphor	ma			6 weeks
4392X		xaminer		Q.	wmo	_					5 days
X			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits	as a consec	quence of):					000013
L	/ pes	dansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Fridiv	m	difficile	Coli	rid		10 days
3	760, Care be executed	ysiclan and ie burial-trans		resulting in death) Last Due to (o	as a consec	quence of):			,		, ,
تَتَ	760 te be e	ysick ne bu	Ical	La. Kigh	it foo	it cel	Whitis				10 days
ું હ	68 rtificat	attending phy for use as th	Med	IF FEMALE: 230 If year output							
	Box eath cert	tendi or use	an/l	23b. Was decedent pregnant 1 Live bir	h 2 Fete	el death 3	□Ectopic pregnanc	у		23d. Date of Month	
	O. E.	by the at tached fo	hysician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	nt at time of o vn	death 5	Other (specify)				
	P.O.	d by letach	۵.	Part II. Other significant conditions contributing to dea	th but not res	sulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
	dS,	signed t d be det	1 by	Tarkin Galler Olganisation		3	, , , -		1 🗆	Yes 2. KQNo 3	☐ Probably 4 ☐ Unknown
	O.C.	bluods	Completed						24a. Was	an 24b. We	re autopsy findings available
	Sec e law	s certificate has birector, page 2 s	I du						auto	ppsy price ormed? dea	or to completion of cause of ath?
	a = =	ficate r, pa		OF Was seen referred to medical				26 Place of I	1 ☐ Yes Death   Check only		]Yes 2□ No
	Vit	certi	o Be	25. Was case referred to medical examiner?  1  Yes 2  Ho Hospital: 1  Hospital:	patient 2	∃ FR/Outpati	ent 3 DOA Ott	han		idence 6 □Other	(Specify)
	<u>a</u> ₹	ar this eral d	<b>I</b>	27. Manner of Death 28a. Date of		28b. Time Injury	of 28c. Inju			how injury occurred	
	iding and	Afte e fun	atlo	1V⊒Matural 5 ☐ Pending (Month) 2 ☐ Accident investigation	, Day 1 sai)	IIIJuiy		Yes 2 No			
	Division of Vital Records,	ector by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of buildin	of Injury - At h	nome, farm, s	street, factory, office			(Street and Number own, State)	or Rural Route Number,
	وَ مَ	s afte	Certification:								
	lospi	t hour	ical	29a. Certifier 1 Certifying Physician: To the 2 Medical Examiner: On the ba	sis of examin	nowledge, de nation and/or	ath occurred at the ti investigation, in my	ime, date and pl opinion, death o	ace, and due to the ccurred at the time	e cause(s) and mann , date and place, and	ner as stated. d due to the cause(s)
	ş	within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29b. Signature and title of certifier	er stated.		29c. Licen	se number		29d. Date signed (	Month, Day, Year)
	P	± 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		N V	<b>\</b>		RE	5-00		Tarma	10 than
		.\		30. Name and address of person who completed cause	of death (Ite	em 23a) (Tvn		3-00		Janvary	971/ XU 09
		H		KUSUMA YANAPARTH	TN	\.D.	Sina? A	to soit	al of	Ballim	<b>9</b> 9,2009
		St	ate	31. Date filed (Month, "Day, Year)" 32. P	gistra s Sign	nature		1111		,	
		Regist		FEB 0 3 2009 🔝	racia	B. 36	parkel				

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State o	of Mary	land / Do	epartmen <i>Certificat</i>	it of He e of D	ealth and N <i>eath</i>	Mental Hy	/giene Reg. No.	200	9 027	161
	1. Decedent's Name (First, Middle, Last)									2. Date of De	eath _		3. Time of De	ath
Physicia /Medic		Effie			Sm	ith		Ро	unders	JAN	29 ay	2009	6:009	M
Examin		4a. Facility Name (If not inst	_						ocation of Death		4c.	County of Dea		
*	Union Memorial Hospital						Baltimore							
Funeral		5. Social Security Number	6. Se	ex □M:2DXF	7. Age <i>(In</i>	yrs. last birth	day) If Under	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D		C	rthplace (State or Fountry)	oreign
Director		240-34-7660 Usual Residence of Decede	<u>'                                    </u>		0.					02 1	3 2	6	NC	
yland now		10a. State 10b. Co			100	c. City, Town	or Location						10d. Inside City I	_imits
Mar a-fsl	ctor	MD	NA			Ва	altimo	re					1 <b>X</b> ]Yes 2	□No
be filed within 72 hours after death with the Maryland ntal Hygiene.  Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiter in ust be in afficial.	Funeral Director	10e. Street and Number					10f. Zip				10g. Citiz	zen of What C		
23a ust b	rall	5500 Eldero	n Av	re				212				U.S.	Α.	
er deg	nue	11. Marital Status		12. Was Dec	orces?	in U.S.	13. Was Dece If Yes, spe	dent of Hisp cify Cuban,	panic Origin? (S <sub>i</sub> , Mexican, Puerto	pecify Yes or N o Rican, etc.)	0- 1	<ol> <li>Race - Am Black, Whi</li> </ol>		
s afte	by F	1 ☐ Never Married 2 ☐ 3 🔀 Widowed 4 ☐ Dive		1 ∐Yes If Yes, Gi Year or □	ive No		1 ☐ Yes	<b>X</b> □ No	Specify:			Specify: B	lack	
thou	ed	15. Dec	edent's Ed	ucation		16a. [	Decedent's Usu	al Occupat	tion		16b. Kir	nd of Business	s/Industry	
.e. .e. .m."na 	Completed	(Specify only in Elementary/Secondary (0-	nighest gra	de completed) College (			Give kind of wo life. DO NOT u	rk done du se retired)	ring most of work	king	Fra	nklin	Square	
d with giene	No.	12th grade		6y		]	Psycho	The	raphy			pital		
e file tal Hy d oth	Be (	17. Father's Name (First, Mi	ddle, Last)					1	18. Mother's Nam		e, Maiden :	Surname)		
Ment Ment arked atic e	1º	John Smith							Hattie	Tomli	nson	l 		
2 sho and is m raum		19a. Informant's Name/Rela					_		nd Number or Ru					
l and leatt		Benjamin Po	unde	rs-So					Ave,	Baltım Date		Md cation - City or	21215	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Wastical Examples and the control once.		20a. Method of Disposition			State		Disposition (Na , crematory or o		;			,	,	
artme artme ortant Injury		4 □ Donation 5 □ Oth  21. Signature of Funeral Se				King I	Memori	al P	ark 2/6	5/09	Woo	dlawn	, Md	
Depril Impo		2 Cima		Sek.	ke		March			n 1.			01015	
		23a. Parl 1. Enter the disea shock, or heart failure	se, or com	plications that	caused the	death. Do no	ot enter the mod	waba de of dying,	sh Ave	or respiratory	1mor arrest,	e, Ma	Approximate	=
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/Medical		disease or condition resulting in death)		a	(or as a co	NARY Insequence of		7 1	שלחשבן ל				40 yea	پ
Examiner				b										
i d	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,		(or as a co	nsequence of	f):							
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c	,									
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eath certifi attending for use as	J/Me	IF FEMALE: 23b. Was decedent pregnal	at	23c. If yes, ou								23d. Date of de	elivery	
death atte	ciar	in the past 12 months?			birth 2  gnant at tim	Fetal death e of death	3 ☐ Ectopic p 5 ☐ Other (s					Month	Day Yea	ar
w requires that the descensioned by the	Physician/M	9 Unknown	$\perp$	9 □ Unk	nown									
gned ge det	by P	Part II. Other significant co	nditions o	ontributing to d	death but no	ot resulting in	the underlying o	cause given	n in Part I.	23e. Did	tobacco u	se contribute	to the cause of dea	th?
en si										1 🗆	Yes 2	□No 3□F	Probably 4 Uni	known
law re as be 2 sho	Completed									24a. Wa	s an opsy	24b. Were a	autopsy findings ava	ailable
The cate h	Com									perl 1 □ Yes	formed?	death?		50 01
clan: ertific	Be (	25. Was case referred to m examiner?	edical						26. Place of Dea					
Physic this c	၉	1⊿Yes 2□No			Inpatient		patient 3 D		4 LI Nursing H	lome 5 ☐ Res			ecify)	
Attending Physician: The law requires that the death certi x death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	ion:		ending		e of Injury nth, Day, Ye	ear) 28b. Ti	ime of jury	28c. Injury Work?		28d. Describe	how injury	y occurred		
death death ctor: y the	ficat	3 ☐ Suicide 6 ☐ C	vestigation ould not be	<u> </u>	e of Injury -	At home farm	m, street, factor		es 2□No	28f Location	(Street an	d Number or F	Rural Route Numbe	or.
after Direction	Certification:	4 ☐ Homicide d	etermined	build	ding, etc. (S	Specify)	in, street, lastor	y, onice		City or To	own, State	)	rurai rioute rumbe	1,
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page									e, date and place					
n 24 I	Medical	(Check only 2 ☐ Me one)	dical Exan	niner: On the l and mar	basis of exa nner stated.	amination and	d/or investigation	n, in my opi	inion, death occu	irred at the time	e, date and	place, and du	ue to the cause(s)	
To the common co	Ž	29b. Signature and title of c	ertifier				29	c. License	number		29d. Dat	e signed (Mor	nth, Day, Year)	
<		John	vC.	Wr	11	W).	] !	2006	51276		LAL	N 29	, 2009	
/		30. Name and address of p	erson who	completed cau	ise of death	(Item 23a) (	Type, Print)	Λ	N ( 1)					
		John 31. Date filed (Month, Day,	YearT T	nary	Registrar's	Signature	min 1	1/6W/C	uribul 140s	proul	•			
Sta Registr		EER (	3 200	g les	i legistiai S	B. A	Barka		will Hos					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marques /Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Feb. 13, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland Year. 1 □ M 2 □ X Yrs. 213-12-2760 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middel Evan in critical to notifical some. 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2144 Harman Ave Funeral 21230 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Braun Mary Clam 2 19a. Informant's Name/Relationship (Type. Print)
Kelly L. Pfisterer, granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ler 404 S. Vincent St. Baltimore, MD. 21223 20b. Place of Disposition (Name of Verence) of 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2-3-2009 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crownsville 21. Signature of Funeral Service Licenses Ambrose funeral Home, I 1328 Sulphur Spring Rd. Arbutus, MD. 21227 و 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-trar Due to (or as a consequence of): MARRET PEISTER DIVISION OF WITH PECONDS 1976 Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2-No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed-(Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** February 1, 2009 4:00 A M William Andrew Pillsbury, M.D. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Timonium Baltimore 2525 Pot Spring Road K-109 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Min 1 € M 2 □ F 220-09-8349 86 8/29/1922 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression must be redified at once. Timonium MD Baltimore 1 □Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2525 Pot Spring Road K-109 21093 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Andrew Pillsbury Rose Mary Sedwick ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Pot Spring Road K-109 Vertalee Pillsbury / Wife <u> Timonium, MD 21093</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/5/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 yes /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed E burial-trar Division of Vital Records, P.O. Box 68760, Physician/Medical attending nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for L Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 NER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28e. Place of Injury - At hombuilding, etc. (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1/A 1 ☐ Yes 2 No death. ours after death.

neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral (

20+1

within 24 ho

To the Fune

completely 1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of entitier

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

FALLS RD, #401 LUTHERVILLE MD 210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician 3:00 February 2, 2009 **Parsons** /Medical Patricia 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie <u> Tate Cancer Center</u> Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □XF Months Days Hours 1942 14, Maryland 220-36-4990 Usual Residence of Decedent Director Jan. 67 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Madical Experiment, and so nother at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A. 21122 208th Street Funeral 654 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify. 9 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Transcriptionist of Medical Records North Arundel Hospital 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clendaniel ပ Parsons Marjorie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208th Street Pasadena, Maryland 21122 Susan S. McDonald (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/05/09 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Approximate Interval Between nset and Death immediate Cause (Final disease or condition resulting in death) month Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of anylog Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) has been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 NNo 2 NO 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) To the Hospital v. .....

within 24 hours after death.

To the Funeral Director: Aft Natural 5 Pending Injury 1 □Yes 2 □No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2,2009 D39505

Registrar

DHMH 17 Rev 1/2001

State

Name and address of person who completed cause

DV.

HOSDIF

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Glen Bu

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#30perDVR G888 2/3/09 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:25 A M Geneva Jane Pietrusza J<u>anuary</u> 26 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5320 Dorsey Hall Dr. # 318 Ellicott City Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours Months Days 1 □ M 2 □ /22/1926 83 404-24-6377 Ohio Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 5320 Dorsey Hall Dr. # 318 21043 UnitedStates Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1 □Yes 2 □ No If Yes, Give X 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏌 No Specify: Specify: White <u>}</u> 3 X Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important; If Item 27 is marked other than any injury or other traumatic event, Inc. M. Once. Nurse 12 Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Henderson Mary Villars မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Angie Pietrusza - Daughter 118 Mountain Rd. #2c, Glen Burnie, Maryland, 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 1/30/2009 Elkridge, Maryland <sup>22.</sup> Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 7250 Washington Blvd. Elkridge, Maryland, 21075 permit. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complibations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ance disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p as IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) the I Tyes 20 No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this s after death.
Il Director: After this
od in by the funeral d 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

Ellicott City, Md 21042

30. Name and odress of person who completed cause of death (Item 23a) (Type, Print)

4801 Dorsey Hall Dr.

32. Registrar's Signature

Warren M. Ross

31. Date filed (Month, Day, Year)

FEB 0 3 2009

27,2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JANUARY 28, ŽŽIZI9 **Physician** Louis E. Phips,
4a. Facility Name (If not institution, give street and number)
5aint Joseph Medical 6:25P M /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Towson Baltimore 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1**Ø**M 2□F Months Days Hours Min Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Evaminer must be notified at 1 □Yes 2 No MD Funeral Director Balting 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 21244 items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 9 Specify. 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) General General 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Belle Jones ٩ Walter Phipos

19a. Informant's Name/Relationship (11 pe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Baltimere, ND hipps/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/09 Woodlawn, MS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugm C. Greene luneral six. 21. Signature of Funeral Service Licensee 728 Liberty Rd. Randallstown, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC NON-SMALL CELL LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 5 Other (specify) signed by the a 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has birector, page 2 sl 24a. Was an autopsy performe 2 □No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No after death

Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft e Funeral Di letely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely within 2. and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-29c. License number 2 09 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

L.I.

FEB 0 3 2009

31. Date filed (Month, Day, Year)

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32. Registrar's agnature

OSLER

DRIVE TOWSON MARYLAND 21204

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	-	epartment of F Certificate of		Viental Hyg ا	giene Reg. N.200	9 02767
	Physicia	_	1. Decedent's Name (First, Middle, Last BONNIE SUE	POSNER			- 1	2. Date of Dea Month		3. Time of Death Year 0 9 3.00 PM
	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County o	
		2	LEVINDALE	T 4 /	In our land hindh		I I Under 24 Hrs.	8. Date of Birt		N/A
	Funeral Director		I- I -	M 2 F 7. Age (	In yrs. last birtho	Months Days	Hours Min.	08/24/	v. Year)	Birthplace (State or Foreign Country)     MD
	/land low at		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	r Location				10d. Inside City Limits
	e Man a-f sh tified	ctor	MD BALTIM	IORE	FORE	EST HILL				1 □Yes 2 No
	with th	Director	10e. Street and Number 2013 BRANDY DRIV	<i>'</i> E		10f. Zip Code	21050		10g. Citizen of WI	
	ms 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decedent of H If Yes, specify Cub		pecify Yes or No-		- American Indian,
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married  Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 💥 No		o Rican, etc.)		, White, etc. WHITE
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21215-0036	within iene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retire IT TRAINEI	*		MEDSTAR	HEALTH
р 2	e filed ai Hygi I other vent, t	Be C	17. Father's Name (First, Middle, Last)	1/27011	- NOW		18. Mother's Nan		Maiden Surname	
Maryland	should be and Mental s marked c umatic eve	To	ISIDORE	KRICH		Initian Address (Chron	VIOLET		FISHBON	
Mai	and 2 st ealth and n 27 is n		19a. Informant's Name/Relationship (7)			lailing Address <i>(Street</i> 13 BRANDY			LL, MD 2	
	es 1 ar of Hea fitem:		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □		20b. Place of D	isposition (Name of crematory or other pla		Date		City or Town, State
Baltimore,	Pages tment of I tant: If ite		4 ☐ Donation 5 ☐ Other (Specify	)	FORBANI	CEMETERY		2/2009	ROSEDAI	
Baj	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licent	utter	1	22. Name and Address 8900 REIS	TERSTOWN	ROAD P	IKESVILL	E, MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the cause on each line.			ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	-	NCER				
	Examiner		Sequentially list conditions	b						
7	led Isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury	Due to (or as a c	consequence of)					
<u></u>	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a c	consequence of)	:				
68760,	ate be hysicia the bur	edical		d						
_		/Med	IF FEMALE:	23c. If yes, outcome pf	pregnancy				22d Date	of delivery
. Box	death certi e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at tir	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	:у		Mon	,
P.0	res that the de signed by the a be detached t	Phys	9 ☐ Unknown	9⊟Unknown				Oo Did A	-1	had to the course of death 0
Division or Vital Records, I	w requires that the been signed by the should be detache	by	Part II. Other significant conditions co	ontributing to death but i	not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to		bute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
Seconomic Secono	law as b 2 sl	Completed						24a. Was autor	osy pr	/ere autopsy findings available
alF	The ate		25. Was case referred to medical				00 Disease ( Day	1□ Yes	2 1 No 1	eath? □Yes 2□No
Ž	ding Physiclan:  After this certific funeral director,	To Be	eyaminer?	Hospital: 1 4 Inpatient	2 ER/Outp	atient 3 DOA Ot	hor:	ath <i>(Ch</i> eck o <i>nly</i> o	dence 6 □Othe	r (Specify)
n 0	ing Ph After th uneral	on: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tin	ıry Wo	iry at irk?		how injury occurre	
isio	Attending or death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		/ - At home, farm	M 1 [	Yes 2 No	28f. Location (	Street and Numbe	r or Rural Route Number,
<u>&gt;</u>	크를	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)			City or Tox	vn, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (		ysician: To the best of niner: On the basis of e and manner state	xamination and/					
	To the within To the comple	Me	29b. Signature and title of certifler			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	ŧ		HOWAW H. WO	ZDEHIWUT		200	63327		FEB. O.	1,2009.
	0		30. Name and address of person who				- A . I .	Rist	IMAGE	11 1) 1111
×	Sta	ate	GIZHW WOLDEH 31. Date filed (Month, Day, Year)	32. Registrar	s Signature	, DELVE DE	TKL- ITVE	-, DITL'I	PIUKE,	NO XIUS
	Regist		EER 0 2 2009	Meerin	A. Da	Ben				

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, this

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 02:00 AM DONALD FRANCIS QUINN 2009 Oi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENERAL HOWARD HOWARD COUNTY HOSPITER COLUMBIA, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 88 JUNE 307-21, 1920 MARYLAND 18-9714 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9509 Mellen Court 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 KD Kes 2 No 194

If Yes, Give Year or Dates: 196 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1941 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ Specify: 1961 White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Vice President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert J. Ouinn Anna Lochboehler ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen J. Quinn - Son 10714 Liberty Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 🔀 🕊 remation 3 ☐ Removal from State Atlantic Crematory 02-03-09 Glen Burnie, MD 5 ☐ Other (Specify) M00053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Licen MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BILATERAL PHENMONTA **Physician** 1 week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2415. CHRONIC OBSTRUCTIVE STAGE Pullen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1

Yes 2

No 3

Probably 4

Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No neral Director: / 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) MD.D50404 2009 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATEL, MD 5755 CEDAR LANE Common 21044 D. 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20,2009 January Charles L. Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ore System
7. Age (In yrs. last birthday) YA Maryland Peath (
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Oct 7, Birthplace (State or Foreign Country) **Funeral** Days Year unk Months 1 ▼ M 2 □ F 1914 94 Director 222-05-8871 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show is 1 and 2 should be filed within 72 hours after death with the Maryla of Heath and Mental Hygiene. It is a 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, It is Medican it within must be notified at 1√ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 USA 301 McMechen Street Funeral unk
12. Was Decedent Ever in U.S.
Armed Forces?
1 MYes 2 | No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun once. 361 Boiler House Road Perry Point, MD VA MD Health Care System 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 2 a. Part LEnter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death is that cause on each line.

Out of Pespipole to (or as a consequence of):

Perposition of the control of the c Immediate Cause (Final Physician unkmown disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transi umonic unknown Due to (or as a consequence of): Box 68760, law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate funeral director, page 1 ☐Yes 2 WNo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DPNo 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28a. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated.

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

ame Andun to Invariant Mobinson,

State

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

7 Maryland Nealth Care System, Perry Point, MO21902

29d. Date signed (Month, Day, Year)

09-00836 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Diana Augusta Rosen State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 28, 2009 1501 hrs **Medical Examiner** Diana Augusta Roser 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death northbound I-95 north of Caton Avenue **Baltimore** N/A 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** oreign Country) NY Months Hours 63 Days 108-36-2565 Nov. 22, 1945 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a State Yes 2 X No Volusia Deland 28a-f show FL with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 32720 United States 910 Spanish Lane items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. death 1 Never Married 2 X Married Armed Forces? Yes 2 X No 9 Divorced If Yes. Give Year Yes 2 X No specify Specify: White hours after ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) rraumatic event, the Medical permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is unarked other than injury or other traumatic event, the Medical. Baltimore, MD 21215-0036 Fabric Industry Seamtress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Wilder Be Herb Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Spanish Lane, Deland, FL 32720 Dennis R. Roser - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Crematory Atlantic 1-30-2009 Glen Burnie, MD Other Specify Donation 2. Name and Address of Facility Ambrose Funeral Home, Sulphur Spring Rd. Arbutus. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line. Medical Death a. Smoke Inhalation and Burn Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and . Physician/Medical X AMENDED #1 as noted per ME g888 2/9/09 TT UNPENDED the attending physician ed for use as the burial Records, P.O. Box 68760, The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery If yes, outcome of pregnancy Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ✔ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 ✓ Yes No this certificate the Hospital or Attending Physician: 'hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: , Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes After 28a. Date of Injury 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Jan 28, 2009 Passenger in vehicular accident within 24 hours after deam.

To the Funeral Director: A' Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
northbound I-95 north of Caton Avenue, Baltimore, MD (Specify) Interstate/Express Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 29, 2009 O.C.M.E.

OCME

Laron Locke MD.

ne and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 3:45 Ам Edna Rossi 2009 Anna 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Parkville Baltimore Oak Crest Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Under 1 Hours | Min. | June 4, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Tand 1 □ M 2 🛣 F 89 215-09-5763 1919 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Parkville Maryland Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 U.S.A. 8800 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Clements Samuel Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Rossi/Daughter-in-Law 5 Old Boxwood Lane, Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 02-06-2009 Overlea, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenside 1050 York Road, Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiomyopathi Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes \$□M0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ↓ ☐ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

345 that the death certificate be executed Ö Records, law requires of Vital Division 4*NN*4

nis certificate has been signed director, page 2 should be det this certificate Hospital or Attending Physician: 24 hours after death. neral Director: After the filled in by the funeral within 24 hours a To the Funeral L completely

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience must be notified at

Hygiene.

12 should be filed w h and Mental Hygiei 7 is marked other th

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n

**Physician** 

/Medical Examiner

led by the aftending physician detached for use as the burial

any In

permit. Page Department

Funeral Director

Completed by

Be

ပ

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

30. Name and address of person who Michealle 31. Date filed (Month, Day, Year) State

29a, Certifier

29b. Signature

(Check only one)

Harrison

and title of certifier

CRNP 8800

and manner stated

R171944 completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Walthor Blud, Parkville MD 21234 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 04:40A M TIT Johnson Ross. /Medical George 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Director 719-16-9077 Maryland | Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Macical Examiner is ust be northed at any injury or other traumatic event, the Macical Examiner is ust be northed at any injury or other traumatic event, the Macical Examiner is ust be northed at agree. 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2213 Wonderview Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Manufacturer Paint Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma George Johnson Ross. Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Clare Ross Wonderview Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 130-2009 Towson Maryland 22. Name and Address of Facility Sig era Service Licensee Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the hours after death. physician and the burial-transit Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records. P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elou, M.D DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, OSLER DRIVE TOWSON, MARYLAND 21204 7601 Year) State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3Ó, 4:00 AM January 2009 Valerie Jeanne Rader /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1410 Glenwilde Road Catonsville Baltimore 8. Date of Birth (Month, Day, Year)
Aug. 26, 1951

8. Birthplace (Country) (Germany) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖾 F Yrs. 324-46-4386 57 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, If a Medical Examinar must be notified at once. 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21042 USA 3378 D N. Chatham Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2 No Specify Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles E. Piper Mary C. McCarthy ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1410 Glenwilde Road; Catonsville, MD 21228 Sister Kathy Kuhleman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 2/6/2009 Atlantic Crematory Glen Burnie, MD 21061 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee M01050 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Cesohosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ≥ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 Yes 2 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 515/10 Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 🔀 Natural 1 ☐Yes 2 ☐ No Director: J 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number souli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Delinh heldet 100 UKALWK 405 t DMWD 32. Redistrar's Signature 31. Date filed (Month-Day, -Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

H Known as Arnold Ruso Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19ate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** 23:11 ARNOLD RUDO January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Hospita timore N/A Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**∑**M 2□ F 75 218-28-9818 Director 02/27/1933 MD. Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event, the Medical Examinar must be notified at any Injury or other traumatic event. 1 ☐ Yes 2 ☐ No Director MD BALTIMORE OWINGS MILLS 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number #402 Funeral 4550 CHAUCER WAY. 21117 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □Yes 🐉 □ No Specify. ò Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMMERCIAL REAL ESTATE SALESMAN 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAX RUDO IDA KURLAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Polationship (Type. Print) ROSALYN RUDO / WIFE 4550 CHAUCER WAY, #402 OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 02/01/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gallbladde **Physician** /Medical Examiner Hepatitis seque Italy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse uence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Diabe 1 ☐ Yes 2 XNo 2 X No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Impatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ina 31. Date filed (Month, Day, Year) negistrar's Signature State FEB 0 2 2009 Registrar Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	land / Dep/ <i>Ce</i>	artment of H rtificate of L	ealth and Me Death		liene 200	9 02775
	Physici	an	1. Decedent's Name (First, Middle, La Helen C.	,				2. Date of Deat		3. Time of Death 29 21:37FM
	/Medic Examin		4a. Facility Name (If not institution, gir		enter	4b. City, Town, or	Location of Death	n		ath 1timore
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In	n yrs. last birthday, 79 Yrs.	) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, 11/15/	Year) 9. E 1929 Ma	Birthplace (State or Foreign Country) ryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary Ba-f sh iifi d	ctor	Maryland Baltin	ore	Towson					1 □ Yes 2X No
	ath with th	Funeral Director	10e. Street and Number 111 West Road			10f. Zip Code 212			og. Citizen of What United S of Amer	ica
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantinar must be notified at once.	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 🌣 📆 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	Black, Wi	nerican Indian, nite, etc. White
15-0	"natur	letec	15. Decedent's E (Specify only highest gr		16a. Dece	edent's Usual Occupa e kind of work done d DO NOT use retired;	ition uring most of working		16b. Kind of Busines State	,
212	d withii giene. er than	Completed by	Elementary/Secondary (0-12) 12	College (1-4or 5+)		al worker			Maryla	
and	d be file ental Hy ced othe c event	Be	17. Father's Name (First, Middle, Last Herbert Ne				18. Mother's Name ( Kath	First, Middle, I Leen Cr		
, Mary	ind 2 shoul ealth and Mi 27 is marl er traumati	To	19a. Informant's Name/Relationship Andrew G. Stroup	1		ng Address (Street a				ryland 21157
Baltimore, Maryland 21215-0036	. Pages 1 a tment of He tant: If item jury or othe		20a. Method of Disposition 1 □ Burial 2 <sup>N</sup> □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State (y)		matory or other place meral Bel Air		ary		ll, Maryland
Bal	permit Depar Impor any In once.		21. Signature of Funeral Service Lice	nsee	e	2. Name and Addres aceful Al 2325 Yor	s of Facility ternatives k Road Ti	Funera Monium	al &Crema . Marvlan	tion Ctr.,P.A d 21093
	Care be executed hysician and physician and physician and street is the burlat-transit	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.  PNEUMON  Due to (or as a co  I SCHEM I  b.  Due to (or as a co	IA Insequence of): C CARDI Incequance of): Y ARTER	OMYOPATH	14	respiratory arr	est,	Approximate Interval Between Onset and Death
O. Box 68	the death certifica / the attending pl ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 N No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy			23d. Date of o	delivery Day Year
rds, P.	quires that t in signed by uld be detad	ě	Part II. Other significant conditions of MORBID OBES		ot resulting in the u	inderlying cause give	n in Part I.	23e. Did tot	1/	to the cause of death?  Probably 4 Unknown
al Reco	: The law re cate has bee , page 2 sho	Completed	OBSTRUCTIVE	SLEEP APM	IEA			24a. Was ar autops perforn 1 □ Yes	y prior t	
Zit	/slcian s certifi director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 🗆 DOA Othe	26. Place of Death		e) ence 6 □Other (S	necify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certif with 24 hours atterderath.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	27. Manner of Cath  1 Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, Ye	(aar) 28b. Time of Injury	of 28c. Injury Work M 1 1	at 28 Pes 2 No	id. Describe ha	w injury occurred	Rural Route Number,
Ω	ospital of hours at uneral Duneral Duly filled i			nysician: To the best of m						
	o the H vithin 24 o the Fi omplete	Medical	one)  29b. Signature and title of certifier	and manner stated		29c. License			9d. Date signed (Mo	
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	4		30. Name and address of person who		(Item 23a) (Type, OSLER		OWSON. M	ARVI AN	D 21204	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	barles		11 \ 1 km P11 \	And have als have black to	1
	Registr	ar	FFR 0.32	1009 Lenenia	J 12. 14	Parker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:45 PM John Charles Schmidt January 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months 80 Yrs. 214-26-4759 09/18/1928 Baltimore, MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov MD Baltimore City 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 700 W. 40th Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. Elementary/Secondary (0-12) College (1-4or 5+) TV and Publications News Writer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles F. Schmidt Edna M. Bopp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 6351 Spring Ridge Pkwy. Apt.336 Frederick, MD Carolyn Bindeman/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 02/04/09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licens 8800 Harford Rd. Parkville, MD 21234 3a. P /tl. Enter t + disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s,ock, or he t failure. List only one cause on each line. Approximate Interval Between Onset and Death mme late Caus\* (Final disease or condition resulting in death) neumonia **Physician** ONR Week /Medical Due to (or as a consequence of): **Examiner** polmonary disease hronic obstructive les years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. signed by the a d be detached f 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 1 □Yes 2 No of Vital I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{D} \) Residence \( 6 \) Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After thi funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signate ure and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

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State Registrar Hospito

Balt: More MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Levis
31. Date filed (Month, Day, Year)

Memorial

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7000 ICUAY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) URR HOLY CROSS HOSPITAL MONTGOMERY If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Months NONE CHANYNAM Director 0124 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exphiner must be notified at 1 Yes 2 No Director JESSUP WD HOWART 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 'natural", or items 23a or DRIVE 20794 8 B LINCOLN by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, Item Many injury or other event, Item Many injury or ot College (1-4or 5+) Elementary/Secondary (0-12) TURRAUT THARINI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SENSIE DESMOND SENSIE MASERAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HOLY CROSS HOSPITAL RD SILVER SPRING MD 20910 1500 FOREST GLEN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 21. Signature of Funeral Serve Licensee Wade, Vitector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca e (Final disease or condition resulting in death) **Physician** PREMATURIT 5 minutes EXTREME /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed ng physician and as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 \ Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending Division 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier 🗑 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 261442 2009

Registrar

DHMH 17 Rev 1/2001

State

ERIC MARTIN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASKIN

ROCKVILLE

PIKE

ROCKVILLE

11119

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 30°, 200°9° Physician Robert William Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Center for Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours TXXM 2 216-62-9552 54 Maryland 10/21/1954 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, Ite Padical Exa. wired in ust two rediffied at Maryland Baltimore Essex 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 U.S.A. 302 Stemmers Run Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married M∑Yes 2 No Baltimore, Maryland 21215-0036 1 ∐Yes 2√XNo If Yes, Give Year or Dates: unk. Specify: <u>ک</u> White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Grinder/Polisher Oven Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eleandra Mitchell James Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 302 Stemmers Run Road, Baltimore, Maryland 21221 Kellie Denise Smith (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ol once. **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard, 02/05/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of Funera Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a Partt: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting 13 ath) Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Macroglobulinemin 1 ✓ Yes 2 No 3 Probably 4 Unknown been si should k 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? 1 \( \text{Yes} \) 2 \( \text{No} \) No 2 No 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Fabruity 2, 2009

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

0+1 State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

6.701 32. Registrar's Signature Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day Physician 6:20 am 2, 2009 Snyder February В. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 607 New Jersey Avenue Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 3/19/1922 Virginia Director 219-22-2076 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the "hecical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or 21221 S. 607 New Jersey Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 27 No If Yes, Give Year or Dates: 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify à 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maxey Martha <u>Delano</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1923 Steven Drive Edgewood, Phyllis Ann Landa (Daughter) Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department of Important: If It any Injury or o Holly Hill Mem. Gard 02/05/2009 Middle River, Maryland Fignature of Functal Service 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complication of total and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final year **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2【 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated within 2.

To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

ce Are. Batto, MD2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

0.

31. Date filed (Mar

Registrar

**OCME 2006** 

State

111 Penn Street, Baltimore, MD 21201

3 2009

Laron Locke MD.

31. Date Hold Month

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Stanature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No.2	009 02781
Physic		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day  Tanuary 30	3. Time of Death 2009 11:05 PM
/Med Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Cou	unty of Death
Funera Directo		5. Social Security Number  1	9. Birthplace (State or Foreign Country) Maryland
9		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 🕱 No
h the Mar or 28a-f s e notified	Director	Maryland Baltimore Towson  10e. Street and Number 10g. Citizen	of What Country?
15-0036  72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examiner must be notified at	by Funeral D	1000 E. Joppa Road, #400 Z IZOO  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  11. Never Married 2 Married  12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. In Yes, 17. Never Married 2 Married  15. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	U.S.A., Race - American Indian, Black, White, etc.
Maryland 21215-0036 to 2 should be filed within 72 hours aft the and Mental Hygiene. It is marked other then "netural", or treumatic event, the Medical Event. treumatic event, the Medical Event.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Customer Service  16b. Kind of work ing life. DO NOT use retired)  Customer Service	of Business/Industry tment Store
yland 2 '	To Be Co	George Ortel  17. Father's Name (First, Middle, Last)  George Ortel  Eva Ertel	name)
y, Maryla and 2 should saith and Men n 27 is marke ser treumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To  Ruth Callender / Daughter  419 Fairview Drive, Chestertown, Mailing Address (Street and Number or Rural Route Number, City or To	
of He reference		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location of the place of Disposition (Name of cemetery, crematory or other place)	on-City or Town, State
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Records, The law requires t	complete	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vital Physicien: T this certificate ral director, ps	Be	25. Was case referred to medical examiner?	Other (Specify)
on of ling Phy After this funeral d	Medical Certification; To	- Cod Passible haw being	
Division To the Hospitel or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	dical Co	29a. Certifier (Check only one)  29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and (Check only one)	d manner as stated. ace, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date s  29d. Date s  29d. Date s  29d. Date s  29d. Date s  29d. Date s  29d. Date s  29d. Date s	igned (Month, Day, Year) NUAY 2, 2009
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	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Month	D		ear	3. Time of Death
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	Examin	er	8049 Veterans Highway	,				illers		0.000			Anne A		21
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	/land ow at		10a. State 10b. County		10c. City	y, Town or Lo	ocation			<u> </u>				11	0d. Inside City Limits
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	or 28	Directo	10e. Street and Number				10f. Z	ip Code	~			10g. C	Citizen of Wh		try?
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	ter de item iner n	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		S.   13.	lf Yes, sp	edent of H pecify Cuba	iispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - Black,	White,	etc.
5-0036	ral", or		3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 No	Specify:				Specify:	Wr	iite
2-0	be filed within 72 hours after death with the Maryland Hyglene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	15. Decedent's Educ (Specify only highest grade			16a. Dece	dent's Us	ual Occup	ation during mos	t of worki	ing	16b.	Kind of Busin	ness/Inc	lustry
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altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic e once.		1  Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		lace of Disponentery, drein Hayer				02-04			Burnie	100	
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60,	oe exe	_	resulting in death) Last	Due to (or as	a consequ	uence of):									
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×	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome	pf pregna	incy							23d. Date	of dolivo	
.O. Box	death e atter d for u	iciar	in the past 12 months?	1□Live birth 4□Pregnant at			□Ectopic □ Other (	pregnancy specify)	/			_	Month		Day Year
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	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions con	tributing to death bu	ut not resu	ulting in the u	ınderlying	cause give	en in Part i	•					e cause of death?
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Division or	Ing Phy After thi		27. Manner of Death 1 ★ Natural 5 Pending	28a. Date of Inju (Month, Day		28b. Time o	of	28c. Injur Wor			28d. Describ	e how inj	jury occurred		·
<u>s</u>	ttend death. :tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	29o Place of init	In - At he	mo form at	M root fact	L	Yes 2		006 1 41	(011			
<u>&gt;</u>	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	4 ☐ Homicide determined	28e. Place of injubuliding, etc.	c. (Specify	y)	reet, iact	огу, описе		,		n (Street a Гоwп, Sta		or Hura	Route Number,
	ospita hours uneral		29a. Certifier 1 Certifying Phys	ician: To the best	of my kno	wledge, deat	th occurre	ed at the tir	me, date ar	nd place,	and due to t	he cause	(s) and manr	er as st	ated.
	the Ho nin 24 the Fu	Medical	(Check only 2 Medical Examir	and manner sta	ited.										
	Nith Con	2	29b. Signature and the of certifier				2	9c. Licens	e number			29d. E	ate signed (	Month, I	Day, Year)
			20 Name and address of	~~ <u>)</u>	nath //:	. 00a\ /T	Del - P	25	1796	>		1-66	mary	2"	2009
5			30. Name and address of person who con K-Ambala variant,	mpleted cause of d	eath (Item	123a) (Type,	and.	103	GI	en E	Burnu	2 1	11)21	061	
	Sta		31. Date filed (Month, Day, Year)	32. Fegistra	ar's Signa	ture	la No	1		-					Day, Year)  1 2009
	Registr	ar	FFR 0 3 200	19 Lansi		14. ph	WUNC								

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AMEND ITEM#23a, pt1&11, perPHYS. G888, 2/3/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 2009 Summers William Edwin 22 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE C Under 1 Year | If Under 24 Hrs. SINAL HOSPITALUF BALTIMORE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number Days **½**M 2□ F 235-38-3221 80 05-20-1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Sykesville Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 4690 Doncrest Court United States 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No 1945− If Yes, Give Year or Dates: 1967 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Master Sargeant U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delbert Max Summers Cora May Dennison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia R. Summers - wife 4690 Doncrest Court, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X ☐ Cremation 3 ☐Removal from State Atlantic Crematory 01-25-09 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Licensee MQQ053 22. Name and Address of Facility Gary L. Kaufman Funeral Home at - Bronaum MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or cardition) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) few days Due to (or as a consequence of) Few Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respiratory Acidosis Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus type2 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? H/O Cerebrovascular Accident autopsy performed' 20 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner** The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, attending p ate has been signed by the page 2 should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

Director

Funeral

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Be Completed

29b. Signature and title of certifier

Laui (Kgant

FEB 0 3 2009

KANT 31. Date filed (Month, Day, Year) 17

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Pages '

**Physician** /Medical

the Maryland

with

Medical Certification: To Registrar

State

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES 000

HOSPITAL OF BALTIMORE

29d. Date signed (Month, Day, Year)

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	•		rtment of Hi tificate of E			giene Reg. No.	200	וסדכת מ	
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath	<del>-200</del>	3. Time of Death	
	Physicia /Medic		Beverly Snyder						Month 1	Day 19		2:30 p M	
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death		4c. County of Death Prince George's			
-			Laurel Regional Ho 5. Social Security Number 6.		(In yrs. last birt	hday)	Laurel	If Under 24 Hrs.	8. Date of Bir				
ı,	Funeral Director		579-40-1776	I□M 2XXE		Yrs.	Months Days	Hours Min.	(Month, Da 4/18/19	ay, Year)		thplace (State or Foreign ountry) ington, D.C.	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation					10d. Inside City Limits	
	Maryl -f sho	ţō	MD Anne Aru	ndel	Lau	rel						1 ∐Yes 2√√No	
	r 28a	Directo	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Co	ountry?	
	th with		320 Old Line Ave	nue			20724			Ur	nited Sta	tes	
	r dea	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - Ame Black, White		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I're Medical Examinar must be notified at once.	þ	1 ☐ Never Married	1 ∐Yes 2 💢 № If Yes, Give Year or Dates:	D	1	□Yes 2√2No	Specify:				hite	
5-0	72 ho	etec	15. Decedent's <b>E</b> (Specify only highest gr	ducation ade completed)	16a.	Deced (Give k	ent's Usual Occupa kind of work done de O NOT use retired)	tion uring most of work	ing	16b. Ki	nd of Business/	Industry	
121	vithin sne. <b>than</b> "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)		O NOT use retired) Hygienist				D		
d 2	Hygie Hygie other		17. Father's Name (First, Middle, Las	<u>'</u>	De			18. Mother's Name	e (First, Middle		Dentistry Surname)	У	
an	ld be lental ked o ic eve	To Be	Lewis Pa					0:	rris Webb	,			
ary	2 should be and Mental Is marked of raumatic ever	-	19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing	g Address (Street a				r Town, State, 2	Zip Code)	
ž	and 2 ealth a n 27 is ner tra		Joseph E. Snyder /	Husband	3:	20 0	ld Line Ave	nue, Laure	1 Md 207	24			
ore	es 1 a of He of He <b>fitem</b>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	] D Ot-t-			ition (Name of atory or other place		Date		cation - City or	Town, State	
<u>Ĕ</u>	Pages ment of ant: If its ury or o		4 ☐ Donation 5 ☐ Other (Speci	fy)	Atlantic		ematory, LL	i	-2009	Glen	Burnie	. Marvland	
Baltimore, Maryland	permit. Departi Imports any Inj		21. Signature of Funeral Service Lice	<sup>nsee</sup> Vernon R. Mortician Lic#			Name and Address	F	leck Fune Laurel	ral H	lome, Inc.		
	_		23a. Part 1. Enter the disease, or con	plications that caused	the death. Do r						.,	Approximate Interval Between	
T <sub>en</sub>	Physician		shock, or heart failure. List only	one cause on each line	pneur	nonia	3				7	Onset and Death  2 weeks	
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):										
	Examiner		Sequentially list conditions,				ulmonary d	.sease				many years	
	ed sit	ine	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	of):							
	and and	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of	of):							
68760,	ifficate be executed g physician and as the burial-transit			ď	·	,							
<b>189</b>	ifficate g phy as the	edical		u									
Box	Attending Physiclan: The law requires that the death certific refeath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as!	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No	23c. If yes, outcome of	2 ☐ Fetal death		Ectopic pregnancy Other (specify)				23d. Date of de Month	livery Day Year	
P.O.	at the	hys	9 🗆 Unknown	9 ☐ Unknown									
Ś	res that the de signed by the a be detached	by §	Part II. Other significant conditions cardiac arre		t not resulting in	the un	derlying cause give	n in Part I.				the cause of death?	
ord	w require s been sign should b	ted		St					1,100	Yes 2		robably 4 Unknown	
Division of Vital Records,	Physiclan: The law r this certificate has b ral director, page 2 sh	Completed	hypoxia						24a. Was auto perfo 1 □Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of	
<u>ta</u>	lan: rrtifica ctor, p	Be C	25. Was case referred to medical					26. Place of Deat			To les	2 🗆 140	
Ž >	hysic his ce I direc		examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatier	nt 2 ER/Ou	tpatient	: 3 ☐ DOA Othe	r: 4 ☐ Nursing Ho	me 5 ☐ Resi	idence (	6 □Other (Spe	ocify)	
o L	iding Phi h. After thi funeral	on:	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injur (Month, Day)		ime of njury	28c. Injury Work	?	28d. Describe	how injur	y occurred		
sio	tendi leath. tor: / the fi	cati	2 Accident investigation 3 Suicide 6 Could not to					′es 2 □No	201 1 1				
<u> </u>	or Attencatter death Director:	Certification: To	4 ☐ Homicide determined		(Specify)	m, stre	et, factory, office		City or To	Street an wn, State	d Number or Ri	ural Route Number,	
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			hysician: To the best o miner: On the basis of									
	the F the F the F mplet	Medical	one)	and manner stat			29c. License						
	<b>6</b> ≥ 6 8		29b. Signature and title of certifier		X					290. Da	te signed (Mont	n, Day, Tear)	
•	0 4		20. Name and address of passes with	completed course of de	eath (Itam 222)	Type		5515		Janu	uary 19,	2009	
	20			10724 Little	Patuxent			200 Co	lumbia, N	4D 21	1044		
	Sta Registr		FEB 0 3 2009	32. Registra	r's Signature	ako	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00890 State of Maryland / Department of Health and Mental Hygiene Ron San Filipo 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 30, 2009 1025 hrs RONALD SANFILIPPO **Medical Examiner** J c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign CountryCalifornia Days Months Hours Director 561-68-6922 04/07/1947 1XX M 2 Usual Residence of Deceden 10d. Inside City Limits 10c. City. Town or Location XX Yes 2 No is 23a or 28a-f show ie notified at once. 28a-f show Santa Clara Los Gatos California 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 300 College Avenue 95030 IISA the Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. or items must be Armed Forces White etc. 1 XX Never Married 2 2XX No Yes White Yes 2XX No specify: Specify: Widowed Divorced If Yes, Give Year hours after narked other than "natural", event, the Medical Examiner 9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 ltment of Health and Mental Hygiene raut: If item 27 is marked other than "r 21215-0036 Christian Ministry 5+ Priest 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Igantius Sanfilippo Catherine Hilie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) or other traumatic 2 PR 300 College Avenue Los Gatos, California 95030 John Privett SJ 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition Baltimore, crematory or other place) Burial 2XX Cremation GreenMount Crematory 02/02/2009 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Fune 6500 York Road Baltimore, Maryland 21212 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on Medical Death Drowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  $\overline{X}$  AMENDED #1, as noted, 23a,PII,27,28a-f, permE, g888 2/17/09 X UNPENDED

23c. If yes, outcome of pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pregnant at time of death

Live hirth

Unknown

requires that the death certificate be executed Records, P.O. Box 68760,

IF FEMALE

23b. Was decedent pregnant in the

29b. Signature and title of certifier

Ling Li, MD

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

1 Yes 2 No 9 Unknown

past 12 months?

Physician/Medical attending physician for use as the burial ģ Completed certificate has b ector, page 2 sh Be Certification: To Director: d in by the f Funeral

Multiple Cuttin	<u>g wounds</u>			1,0	
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical		2	6.Place of Death (Check	only one)	
examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2 🗸	ER/Outpatient 3 D0	OA Other Nursir	ng Home 5 Residenc	e 6 Other:
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) Fd 1/30/09	28b. Time of Injury 2 FD 9:30 am	8c. Injury at Work?  1 Yes 2 X No	28d Describe how injury subject cut himself	and drowned
3 X Suicide 6 Could not b determined	e 28e. Place of Injury - At h	ome, farm, street, factory, bathtub at		28f. Location (Street and or Town, State) 89 Ave. #115 H	Number or Rural Route Number, City OI New Hampshire yattsville, MD
one) 2 Medical Examiner:	in: To the best of my knowled On the basis of examination a and manner stated.	ige, death occurred at the and/or investigation, in my	time, date and place, and opinion, death occurred a	due to the cause(s) and reat the time, date and place	manner as stated. e, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

Fetal death

Other (Specify)

3 Ectopic pregnancy

DHMH 17 Rev 1/2001 OCME 2006

Division of Vital

24 hours after death.

within 2.

Medical

State Registrar gistrar's Signatu

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

Yes 2 No 3 Probably 4 ✔ Unknown

29d. Date signed (Month, Day, Year)

January 31, 2009

Day

Year

Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death edent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner hrist Date of Birth (Month, Bay, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 💢 F -30-4616 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Wolldal Examiner must be notified at 1 Yes 2 □ No Director MD timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify ρ 3 Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (The Form C Thomas Good Balto-MD lurner 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or of once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Ser OFK Rd. Balto Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ying, such as cardiac or respiratory arrest o not ente Immediate Cause (Final **Physician** COUV zmanns disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial signed by the attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SANK 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □Yes 2 Who 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sl 1 ☐Yes 2 ☐ No 1 □Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. 110 Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 5 ☐ Pending investigation 4 hours after death.

uneral Director: Aftely filled in by the fur М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Within 24 hours are.

To the Funeral Dir. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature apd-title of certifier 29c. License number 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tourson mo 31. Date filed (Month, Day, Year) 32. Registrar's Signati State 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shaw )dell 4b. City, Town, or Location of Death BALTIMPLE annon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N 04 if Under If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number Year 8. Date of Birth (Month, Day, **Funeral** Year) 1 XM 2□ F Months Days Min 213.28.9119 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 ☐ Yes 2 No MD Completed by Funeral Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 2 Kincheloe 12. Was Decedent Ever in U.S. Armed Forces? 1 \ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify Specify: 30ck 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pecia 12th grade years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be Sarah Shaw ည 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimore MID 21207 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) DWINGS Mills, MD 02/06/09 c. Greene Funeral SVCs 21. Signature of Funeral Service Licenses Van Kandallstown MD21133 23a. Part 1. Enter the disease, or complications that caused the shock, or he of failure. List only one cause on each line Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** "7Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Et leading to immediate cause. Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physlcian: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. à 1 🗌 Yes 2 1 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? rostose 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Medical Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural To the noop after death.

Within 24 hours after death.

To the Funeral Director: Aft 1 Natural 1 □Yes 2 □No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number

State Registrar

31. Date filed (Month, Day,

Year

30. Name and address of person

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

amend #5 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Nellie January 28, 2009 \_Irene\_ Swanson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 613 Cromwell Whye Lane Monkton Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 231–20–3756 **Funeral** 1 □ M 2 🔯 F Months Director 80 March 18,1928 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Cromwell Whye Lane 21111 Funeral USA 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after de Ital Hygiene. d other than "natural", or items Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 06 Nursing Assistance Nursing n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be filment of Health and Mental Hiant: If Item 27 is marked ot F1eet Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other traconce. Sheila Irene Saunders/Daughter 613 Cromwell Whye Lane, Monkton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 Other (Specify) Maryland Veterans Cemetery Owings Mills Maryland 21. argnature & Furtire I service Lion 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. 23a. Part1. Enter le di lease, or complicatio s that ca shock, or he art fail lire. List only one ci use on ea. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Caute (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last (or as a consequence of) Due to Examiner The law requires that the death certificate be executed to (or as a consequence attending physician and for use as the burial-tran Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔀 No Month Day 5 ☐ Other (specify) P.O. I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco arse contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of eause of death?

1 □Yes 2 □No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending n 24 hours after death.

Pe Funeral Director: Ailletely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18822 February 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard C. Habersat, M.D., 111 Mt. Carmel Road, suite 500, Parkton, MD

Date filed (Month, Day, Year)

32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State RECORD FEB 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:20 PM Elizabeth Jane Scheder 30 2009 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Timonium Baltimore Stella Maris Hospice if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2□**y** Months Hours Min. 216-38-4181 69 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Evan inversion to rotified at MD 1 ∐Yes 2X No Director Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number with 21093 USA 12000 Tralee Rd. #201 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo Race - American Indian. 1 ∐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5-0036 1 ☐Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, Item Mades once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education/Medical 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Karl Brantley Watson, Jr. Maxine Elizabeth Malony ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Tenby Ct., Timonium, MD 21093 Sandra Elizabeth Kick/daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/3/09 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Signatus of Funda Service Lichn 2. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD Clar sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line. 23a. Part 1. Enter he sease, or complications that caushock, or heart follure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Fine I **Physician** disease or condition resulting in de MELANOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisses of Jury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-tran Due to (or as a consequence of): nding physician use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🗶 No atten 3 🗆 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) ned by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perfori 2**X** No 1 🗆 Yes 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \mathbf{X}$  Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death neral Director: / filled in by the f 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) oneX Nurse Practitionerner stated. 29b. Signature and Me of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signafure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Sidney Ray Smith 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN SQUARE HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. Day Year) 1928 9. Birthplace (State or Foreign Country) Alabama 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 416-32-6481 1**X** M 2□ F Months Days 80 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2 👿 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 937 Woodlynn Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2**X** No ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural". Completed permit. Pages 1 and 2 should be flied within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, Tre Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Armco Steel 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney J. Smith Virgie Wilson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irlene Smith /wife 937 Woodlynn Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2/6/09 Rossville MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave. Balto. MD Colub Connelly Funeral Home of Essex 21221 annell 23a. Part 1. Enter the disease, or comblications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Infarction myocardial /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □Yes 2 ☑ No spital or Attending Physician: Theors after death.
neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) 2-1-2009 RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

9000 FRANKLIN

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** Sikorski JEANETTE 3009 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BAUTIMORE Roberts Avenue MIDALK Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex Funeral 1 M M F Months 216-28-666 1931 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1. Yes 2 □ No Baltimore Director MD DUNDALK 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 51593 23a 6737 SULSUL Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White ŏ 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 XWidowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) BAUTIMORE school WORKER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in nent of Health and Mental ant: If Item 27 Is marked o margherite EDWARD other traumatic 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BAUTIMORQ Me 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If It, any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Ceemore 2-3-2009 BAUTIMORE 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 2134 WILLOWSPRINGE ASHIBN F. W. P.A. BRADEL BAUTINONE MDZIZZZ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NEURDENDORKINE /Medical Due to (or as a consequence of) PRIMARY UNKNOW **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 12 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 \( \sum \) Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 □ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, D 16619 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print) 9940 FRANKUN SOWARF DR. NOTTINGHAN 50A Registrar's Signature State Registrar

			For State Registrar	State	of Marylan		artment of F			iene <sub>99. No.</sub> 200	9 02792
			Decedent's Name (First, Middle)	e, Last)					2. Date of Deat	h	3. Time of Death
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	Examin		4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City, Town, or	Location of Death		4c. County of D	Death
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	Funeral		5. Social Security Number 082–10–7646	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, 6/28/19	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		90				0/20/13	10	110
	ylano how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
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T.	Pages 1 nent of Hi ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from			sition (Name of matory or other plac			20c. Location - City	or Town, State
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ם מ	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service	Licensee	44-	C			_		Cremation nie, MD 21061
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	/Medical		disease or condition resulting in death)	a	(or as a conseq	-					10 days
E	Examiner		Sequentially list conditions	b. 9	EME	MM	A				- YEAR
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> . 5 i	nysic his ce I direc	٦ ا	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing H	lome 5 🗆 Reside	nce 6 Other (	Specify)
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	to the hospital of Attending Physician: The law requires that the death certific within 24 hours after deep. Within 24 hours after deep. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as			ng Physician: To th							
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Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

	1	For State Registrar	State of Maryland	Cert	ificate of	Death		eg. No. 2	9 0279
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/Medica Examine	4.	a. Facility Name (If not institution, give st Anne Arundel Medic	cal Center		Annap			Anne A	
uneral rector	1	47-07-0095	M 2□F 7. Age (In yrs. la 93		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	, Year)	Country)  NJ
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sa or 28a- t be notiff		Oe. Street and Number 800 Bestgate Road	đ		10f. Zip Code 214			10g. Citizen of What USA	
	by Funeral	11. Marital Status  1 Never Married 20 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	-	/as Decedent of I Yes, specify Cub ☐ Yes 2X No	Hispanic Origin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, V Specify:	
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other th		12 17. Father's Name ( <i>First, Middle, Last</i> )		Execut	DIAG ATC	18. Mother's Na	me (First, Middle,	Maiden Surname)	urneo
raumatic event, the	2	Anthony Saquella		10h Mailin	a Address (Stree	Clara	Selaro	li er, City or Town, Sta	te, Zip Code)
T Is m traum		19a. Informant's Name/Relationship (Type Ralph A. Sequella		1	-			ille, NJ	08012
int: If Item 27 I	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State Net	emetery, crem w St. 1	sition (Name of natory or other play Mary!S	ace) 2/	Date 4/2009	20c. Location - City Bellmawr	
Important: I any Injury o once.		4 □ Donation 5 🗷 Other (Specify)  21. Signature of Funeral Service License		Cemetei hall <sup>22</sup>	. Name and Add	L. Stev	ens Fune	ral Home	Inc. , MD 21230 Approximate
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last, Month 1954 M **Physician** January iam /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number last birthday 8. Date of Birth (Month, Day, **Funeral** 67 213-38-9206 3/29/1941 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State Show ral", or items 23a or 28a-f sho Examiner must be notified at PA Lancaster Ho1twood 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 38 Camilia Lane 17532 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White 3 2 should be filed within 72 now....th and Mental Hygiene.
27 Is marked other than "natural", or 1 ☐ Yes 2x No Baltimore, Maryland 21215-0036 Specify Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ Planned Giving Adviser Non-Profit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic everants in the property of the Helen Bennett William D. Smoot Sr. ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Camilia Lane, Holtwood, PA 17532 Elaine Smoot / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 TCremation 3 Removal from State Ardent Crematory 1/29/2009 Hanover, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Cryptogenic Organizing Immediate Cause (Final PHEUMONIA month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a contradamos of: The law requires that the death certificate be executed d by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year Day in the past 12 months? 1 Yes 2 9 Unknown 2 No 9 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary artery disease 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? 2 No 1 Yes 2 No After this certificate 26. Place of Death Check onl one 25. Was case referred to medical Be examiner? Hospital: 1 24mpatient Other: 4 \sum Nursing Home 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 Tyes ၉ 28c. Injury at Work? completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death Certification: Division (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending investigation To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 2 🗌 No 1 🗌 Yes 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only

State Registrar

Peloquin Joanna Registrar's Signa erun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Danna Keloquen

29b. Signature and title of certifier

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

January 88,2009

DHMH 17 Rev 1/2001

RES-000

			For State Registrar	State of Ma	ryland	/ Depa	artmen rtificat	t of H e of L	lealth a Death	and M		giene Reg. No. 2		02796
			Decedent's Name (First, Middle, Last)								2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		Beverly Sc	hoense	ıd						Jon Month	Day	Year 2009	1215aM
and the same	Examin		4a. Facility Name (If not institution, give s	street and number)		T T 0 1	4b. City,		Location	of Death			ounty of Death	
			SEASONS HOSPICE @ I			IIAL st birthday)	If Under		If Under				ALTIMOR	
	Funeral Director			M 2ØF	(111 yrs. 1as	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 09/13/	1 929	Cour	lace (State or Foreign ltry)
	ס		Usual Residence of Decedent		- '						03/ 10/			
	arylar show	<u>_</u>	10a. State 10b. County		10c. City,	Town or Lo							1	0d. Inside City Limits 1 ∐Yes 2 🛣 No
	the M 28a-f	Director	MD BALTIMO  10e. Street and Number	KE		BAL	TIMOF					10a Citiza	n of What Coun	
	3a or	0	4745 BELLE FORTE	RΛΔη				21208	3			-	SA	uy.
	ms 2	Funeral		12. Was Decedent Ev	er in U.S.	13.1				gin? (Spe	ecify Yes or No- Rican, etc.)		. Race - Americ	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventral rate must be notified at	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give	)		irres,sped 1∐Yes 2		n, Mexicar <i>Sp</i> ec <i>ify:</i>		rican, etc.)		Black, White, e	ITE
Maryland 21215-0036	tural	ed t	15. Decedent's Educ	Year or Dates:	- 1	16a. Dece	dent's Usua	l Occupa	ation			16b. Kind	of Business/Inc	lustry
215	a. In "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give	kind of wor DO NOT us	k done d	uring mos	t of workii	ng			,
21	ed within ygjene. er than " t, the Me	Con	12	001.090 (1 101.01)		E	00KKE	EPE	₹			R	ETAIL	
nd	be file	Be	17. Father's Name (First, Middle, Last)	I/D A	II.C						(First, Middle,	Maiden Su	,	ED
ΣŠ	2 should be and Menta is marked aumatic ev	၉	I SADORE  19a. Informant's Name/Relationship (Typ.	KRA	0.5	10b Mailir	a Address	(Stroot o		EARL	J Pauto Numbo	e City as T	ZELN own, State, Zip	
Ma	alth an 27 is i		LEONARD SCHOENFELD		n		_						MD 212	,
re,	item ?		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Nam	ne of	- 1		ate		tion - City or To	
Ë	Pages ment of ant: If ite ury or o		1	emoval from State			VETER		0	2/03,	/2009	OWIN	GS MILL	S, MD
Baltimore,	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service License	е		22	. Name an						& BROS ESVILLE	., INC. , MD 21208
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on			Do not ent								Approximate Interval Between
4	Physician	1	Immediate Cause (Final disease or condition			0 1	. otom.		ASE	- 40	ve lu	n /	) seule	Onset and Death
e.	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):								
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a		nce of):								
/	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events											
oʻ	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):								
8760,	physic the bi	dical	d											
9 X	eath certific attending p	/Me	IF FEMALE:	Bc. If yes, outcome of	nregnand	'V								
Вох	atten for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal de	eath 3	Ectopic pr					230	d. Date of delive Month	ry Day Year
P.O.	w requires that the d s been signed by the should be detached	hysi	9 Unknown	9 ☐ Unknown				<i></i>						
S,	gned go det	by P	Part II. Other significant conditions con-	•		•	, ,				23e. Did to	bacco use	contribute to th	e cause of death?
ord	equire	ted	Pharmon-a								1 🗆 Y	es 221	No 3□ Prob	ably 4 Unknown
3ec	m 0) 01	Completed	Dronchis M.	ell. + us							24a. Was a	sy	prior to con	osy findings available npletion of cause of
a	hysician: The la nis certificate ha director, page 2										perfor 1 🗆 Yes	2 No	death? 1 ☐ Yes	20 No
5	s certi	Be c	25. Was case referred to medical examiner? 1 ☐ Yes _2 ☑ No	ospital:	• 2□ EE	2/Outpation	+ 2□ DO	Othe			(Check only or		ZiOthan (O	· // ·
o	ding Phy h. After this funeral o	n: To	27. Manner of Death	28a. Date of Injury	28	Bb. Time of Injury		Bc. Injury Work	at	rsing Hor	8d. Describe h	ow injury or	ccurred	) Hospee
io	tendin Jeath. tor: Aff the fur	atio	1 Natural 5 Pending 2 Accident investigation	(World, Day,	rear)	ii ijui y	М		es 2□1	No				
Division of Vital Records,	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home (Specify)	e, farm, stre	et, factory,	office		2	t8f. Location (S City or Town		lumber or Rura	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one)  (Check only one)	er: On the basis of e	examinatio	edge, death n and/or in	occurred restigation,	at the tim	ne, date an pinion, dea	d place, a th occurre	and due to the ded at the time, o	cause(s) an	nd manner as st ace, and due to	ated. the cause(s)
	To the Hos within 24 ho To the Fun completely	Mec	29b. Signature and title of certifier	and manner state			29c.	License	number		2	29d. Date s	igned (Month, L	Day, Year)
			Cerale.			n.		7 7	20	7 -2		To-		0 2009
	5		30. Name and address of person who cor	npleted cause of dea	th (Item 2	3a) (Type I	Print)						ح رمان	2001
	)		Allen J- Chi	-cus n.	o Ciat-	531	0	2 (0	Ca	4.7.	Range			L1133
	Stal Registra		31. Date filed (Month, Day, Year) FEB 0 2 2009	. Hegistrar	a aignatur	han	11							
-	MH 17 Rev 1/20		FEB V & 2009	persua	F.	guar	darker.							

			1 - For State Registrar	Oldio of Me	ii yidiid / D	Certificate of	Death		Reg. No.	009	02191
	Physici	an	1. Decedent's Name (First, Middle			·		2. Date of Dea	ith Day	r Year	3. Time of Death
	/Media	cal	ALFRED	STRAUS	SS			Janua.	M 31	2007	0215 M
	Examir	er	4a. Facility Name (If not institution SEASONS HOSPICE		LINCDIT		or Location of Deatl	n		unty of Death	<b>)</b> [
	Funeral		5. Social Security Number	6. Sex 7. Age	HOSPIT	nday) If Under 1 Year		8. Date of Birtl	h	BALTIMOI 9. Birthpla	ice (State or Foreign
	Director		090-24-2176	1 💢 M 2 🗆 F	87	rs. Months Days	Hours Min.	10/02/1	921	GERI	MANY
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				100	d. Inside City Limits
	Maryl -f sho	ţō	MD BAL	TIMORE	В	ALTIMORE					1 □Yes 2√□No
	n the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Countr	
	23a c 23a c ust ts	ral	2 DEAUVILLE CO	OURT, #1B		21	1208			USA	
	er dea Items	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14.	Race - America Black, White, et	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Exeminal roust be notified at	þ	1 ☐ Never Married 2 💢 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes 2 🕅 N If Yes, Give Year or Dates:	10	1 □Yes 2 🔀 No	Specify:		Spe	ecify: WHI	ΓΕ
2-0	72 hou	Completed	15. Decedent (Specify only highes	t's Education		L Decedent's Usual Occu 'Give kind of work done		kina	16b. Kind o	of Business/Indu	stry
2	ithin 7 ne. han "r	mple	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retire			LATUES	IC MANUE	- 4 0 - 11 0 - 0
2	iled w Hygie ther t		17. Father's Name (First, Middle,	last) 4		EXPEDITER	18 Mother's Nan	ne (First, Middle,			FACTURER
an	ld be i ental ked o ic eve	To Be	EMANUEL	STRAUS	is		FRIED		HAAS		
ary	shou and M s mar umat	-	19a. Informant's Name/Relations			Mailing Address (Stree					Code)
Σ.	and 2 ealth n 27 i		BETTY M. STRAL	JSS / WIFE		DEAUVILLE C			<u>·</u> _	MD 2120	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandance must be notified at once.		20a. Method of Disposition 1 X Burial 2 □ Cremation	3 ☐ Removal from State		Disposition (Name of crematory or other pla				on - City or Tow	
Ħ	iit. Pa artmer ortant; njury		4 ☐ Donation 5 ☐ Other (Si		BALTIM	ORE HEBREW				TERSTOWN	
Ba	Department of the post of the		Matt	Licerisee		22. Name and Address 8900 REIST	EDSTOWN I	L LEVINS	ON & E	BROS., I LE. MD	NC.
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused	the death. Do n					1	Approximate nterval Between
an.	Physician		Immediate Cause (Final disease or condition	Reso	ivaten	x Failus	E				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or is a	consequence o	1	-			(0	
	Lxammer	7	Sequentially list conditions,	b. Due to lor as	conce wance o	956					
Τ	uted d insit	Examiner	Cause (Disease or injury	- 1	mic O	bstructu	e Pulm	CVU DIS	G-(15)	0	
/ O	exectan and and rial-tra		that initiated events resulting in death) Last	c Due to (or as a	consequence o	j):	- 101172	7 1	المويسان الساعة		
68760,	rtificate be executed ng physician and as the burial-transit	Medical		d							
9 ×	certific ding p		IF FEMALE:	23c. If yes, outcome of	of pregnancy				004	Data of delivery	
Box	death e atter	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2	2 🗌 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy			Date of delivery Month D	ay Year
P.O.	t the by the	hys	9 Unknown	9 Unknown							
S,	es tha igned be del	by P	Part II. Other significant condition	ons contributing to death bu	t not resulting in	the underlying cause given	ven in Part I.				cause of death?
ord	requir een s nould	ted						1 □ Y	es 2□Ne	o 3 ☐ Probat	bly 4 🖼 Unknown
ဒ္ဓင	e law has b	Completed						24a. Was a autops perfor	sy	4b. Were autops prior to comp death?	sy findings available oletion of cause of
g	in: Th ificate or, pag		25. Was case referred to medical				00 Plans ( Day	1 □ Yes	2 🔼 No		□No
Ē	yslcia s cert directo	o Be	examiner?  1 Yes 2 No	Hospital: 1 □ Inpatier	nt 2 🗆 ER/Out	patient 3 □ DOA Oth		th (Check only on ome 5 Resid	-	Other (Specific	HESWS HOPL
5	ng Pho	T:Ľ	27. Manner of Death	28a. Date of Injur	y 28b. Ti			28d. Describe ho			
<u>Sio</u>	tendii eath. tor: A the fu	catic	2 Accident investig	ation		M 1 =	]Yes 2□No				
Division of Vital Records,	or At	Certification: To	4 Homicide determi		ry - At home, fari . <i>(Specify)</i>	n, street, factory, office		28f. Location (S. City or Town	treet and Nu n, State)	umber or Rural F	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death ce within E4 hours after death. The thin E4 hours after death. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier 1 Certifyin	g Physician: To the best o Examiner: On the basis of	f my knowledge,	death occurred at the t	ime, date and place	and due to the c	cause(s) and	d manner as sta	ted.
	the H hin 24 the Fi	Medical	one)	and manner stat	ed.						
	Vit Cor		29b. Signature and title of certifier	Buton		29c. Licens				gned (Month, Da	
	11		30. Name and address of person	who completed cause of de	ath (Item 23a) (1	ype, Print) 35 Smith	- ()(		JUN	van 3	1 2009
	10		br Doboral	1 Burton	78	35 Smit	h Aven	ue su	te zo	3 Kal	timore MO
	Sta		31. Date filed (Month, Day, Year) FEB 0 2 20		r's Signature	arke				-	
	Registr	all	FED V & ZU	US percen	P. 19	acre					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year JANUARY 5.00 AM 28 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Ellicott City Ellcott City Nursing & Rehab If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. Aug 11, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1 □ M 2 X F Michigan 84 376-20-5762 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Columbia MDHoward 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21046 USA 8808 Stonebrook Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No white Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelson H. Gunn Mary E. Stanton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yale Tankus/son 2620 Gold Mine Road Brookeville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Service Lice Ronal S. Wade Director Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardeo Vascillar Dunase Athero Sclewlic Due to (or as a consequence of): denule Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE

**Physician** /Medical **Examiner** the Hospital or Attending Physician; The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show notified at

ral", or items 23a or Examiner must be r

"natural"

other than "natu

item 27 is marked other other traumatic event,

Department of H Important: If ite any injury or ot once,

Director

Funeral

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Completed

Be

P

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examiner physician and s the burial-tran Physician/Medical inding p been signed by the should be detached Ş Q Completed has e 2 certificate ha Medical Certification: To Be this funeral After within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

23	b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 □Ectopic			23d. Date of delivery  Month Day Year
Par	t II. Other significant conditions	contributing to death but not re	sulting in the underlying	cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Onknown
_					24a. Was an autopsy performed? 1 Yes 2	
25.	. Was case referred to medical			26. Place of Dea	ath (Check only one)	i i
	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	□ER/Outpatient 3□[	OOA Other: 4 Nursing I-	lome 5 Residence	6 □Other (Specify)
27.	Manner of eath  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not I determined		nome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29		hysician: To the best of my kn				e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

Read

306

29d. Date signed (Month, Day, Year)

Kallenne MD 2/221

January 28 200 8

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) 201-109 Back River Sabapathi NICK 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 10:15 pM 29, 2009 January **Physician** Helen Louise Turner /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 1330 Meadowvale Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number Days Hours **Funeral** 1 □ M 2 1 F 1930 Maryland Jul. 10. 78 218-24-6363 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location s filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinational Beautified at once. 10a State 1 □Yes 2 No by Funeral Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number United States 21060 1330 Meadowvale Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Company Mail Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Schwartzbeck Hennigs Whalen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1330 Meadowvale Road, Glen Burnie, MD 21060 Carolyn A. Dawson - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Atlantic Crematory Date 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 01-31-09 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of eral Service Licer 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760, Physician/Medical attending p 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant 3 Ectopic pregnancy Day 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown in the past 12 months? 5 Other (specify) 2 □No TYes the 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Hospital 1 Yes 2 No 1 Inpatient Medical Certification: To this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Injury Attending 5 Pending 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after death To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56950 January 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nnaemeka Obianozie Agajelu 1411 Madison Park Drive Glen Burnie MD 21061

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 3 2009

32. Registrar's Signature park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of May and 9 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MELVIN THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUNS BAUTIMORE HOIPITAL m N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7 / 30 / 52 **Funeral** Months Days Hours Min 1 □ M 2 □ F Director 56 217-54-2706 MD Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Andical Exeminer must be notified at MD N/A 1 XYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1603 Bruce Court-Apt. 21227 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z Mb If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, African filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Spe**A**merican 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7's Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any Injury or other traumatic event, the Made once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnnie Mae <del>Ray</del> Raymond Thompson, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 803 Gretna Court, Brooklyn, MD 21225 Edith M. Thompson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt.,MD Bayview Crematory 2/2/09 22. Name and Address of Facilitari P. Close F. Svs., PA 21. Signature of Fun and Service Lice ee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death he that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) lonal Ph<sub>sician</sub> ral /Medical Due to (or as a consequence of): **Examiner** 4/19010 Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit be executed Due to (or as a consequence of): Box 68760, s been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Carelioni 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed' 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Shoely. M.D. U 00149 49 1126/2009 . On oood 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELI

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 3 2009

32. Registrar's Signatule

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Yea **Physician** JANUARY <u>JOHN IVERSON TOLAND, JR, Ph.D.</u> 2009 12:35FM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 248-44-5485 79 Oct 16, **Director** Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Mudical Evaninal Denotitied at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1

Yes 2□No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 Cedarcroft Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify: White 3 Widowed 4 Divorced Korean Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Iverson Toland, Sr. ပ Martha Keron Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth E. Toland (Wife) 404 Cedarcroft Road, Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 2/4/2009 Baltimore, Maryland 21. Signature of Functed Service Learne Martin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCARDIAL INFARCTION HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE 1 WEEK Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ADVANCED AMYOTROPHIC LATERAL attending physician and for use as the burial-trar MONTHS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No MARKED CACHEXIA 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s RENAL CELL CARCINOMA autopsy performed Yes 2 r this certificate had ral director, page 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of Injury
(Month, Day, Year)

28b. Time of
Injury
28c. Injury Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral i 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) a D56030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMANUEL KOKOTAKIS 7621 TOWSON, MARYLAND 21204 M. D. OSLER DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State acker Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mi	aryiand /		irtment of F <i>tificate of I</i>		and Me	, ,	jiene leg. No. 🤈	nna	กวลก
	hysicia /Medic		Decedent's Name (First, Middle Joseph Bernard							2. Date of Dea Month January	Dav	2009 Ye ar	3. Time of Death 8:00 A M
	xamin		4a. Facility Name (If not institution 6428 Hickory Ove	_			4b. City, Town, or Colum		f Death		4c. Cour	nty of Death <b>Howard</b>	
	neral ector		5. Social Security Number 184–26–1975	6. Sex 7. Ag 1 🔀 M 2 🗆 F	e (In yrs. last bi 73	rthday) . Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day August 1	Year) 5,1935	9. Birthp Coun Pennsy	lace (State or Foreign try) Nania
Maryland	f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Howa:	rd	10c. City, Tow	on or Local						1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the	3a or 28a at be rotti	I Director	10e. Street and Number  6428 Hickory Over			TOME	10f. Zip Code	21044		1	_	of What Coun	try?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al", or items 2 xaminer mus	by Funeral	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ried 1 5 Yes 2 1			Vas Decedent of H Yes, specify Cuba □Yes 2¶ No		gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)	14. F	Race - Americ Black, White, e	etc.
d within 72 hours aft giene.	than "nature the Medical E	Completed		t's Education st grade completed)  College (1-4or 5		(Give F life. D	ent's Usual Occup kind of work done o OO NOT use retired Analyst	luring most	of working	7		Business/Ind	
d 2 should be filed Ith and Mental Hyg	narked other	To Be C	17. Father's Name (First, Middle, Joseph Tofil	Last)				Anna	a Dembe		Maiden Surn	ame)	
1 and 2 shi	ther traum		19a. Informant's Name/Relations  Flaine M. Tofil	hip (Type. Print) (Wife)	6	428 E	g Address (Street dickory Ove	rlook	Columi	bia, Mar	yland 2	1044	
it. Pages 1 ar	rtant: If ite njury or of	ı	20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (S	pecify)	Atlanti	ic Cr	sition (Name of patory or other place	1-	Da -31-20	009	Glen Bu	n-City or To irnie, M	aryland
permi	any l	i ja	21. Sign fure of Funeral Server 23a. Part 1. Enter the disease, or	10-Se M	w1283	¥ 5	Name and Address  itzke Funer  555 Twin Kr	al Home solls Ro	es, In	c Olumbia,	Maryla	ınd 2104.	5 Approximate
Exan	dical niner	Examiner	shock, or heart faily e. List Immediate Cause (Fin disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Le to (or as c. Ly )	a conse uence a consequence a consequence a consequence	of):	SHA			-		6	Interval Between Onset and Death  WHAT  LEWS  JEWS  JEWS
	for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition	d	2 ☐ Fetal death t time of death	5 🗆	Ectopic pregnancy Other (specify)			GO DITAN			ry Day Year
The law requires that the death cert	age 2 should be detached	Completed by	Corryny		i Lenut		uerrying cause give	mmraiti.		1 ☐ Ye	n 24l	3 ☐ Prob  b. Were autoprior to cordeath?	ably 4 Unknown osy findings available npletion of cause of
To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Europa Director, After this contilious has been closed.	in by the funeral director, page	ertification: To Be C	25. Was case referred to medical examiner?  1  Yes	Hospital: 1   Inpatie  28a. Date of Inju (Month, Da) gation not be   28a. Place of Inju	y, Year) ury - At home, fa	Time of Injury	28c. Injun Work M 1 🗆	r: 4 □ Nur	rsing Home	Check only on e 5 Reside	ence 6 Co	urred	
the Hospital in 24 hours a	pletely filled	Medical Ce	29a. Certifier (Check only one)	og Physician: To the best Examiner: On the basis o and manner sta	f examination a	e, death nd/or inv	occurred at the tir estigation, in my o	ne, date and pinion, deat	d place, ar	nd due to the c	cause(s) and late and plac	manner as si e, and due to	tated. the cause(s)
) ! (	cour		29b. Signarute and title of contifie	who	ooth /lter 00 \	/T	29c. License	3486	3		01-7	ned (Month, L	Day, Year)
-	Stat		30. Name and address of person  STOW DUCK  31. Date filed (Month, Day, Year)  FFR 0 3 26	on 110		TUC	Potaes	PL	Co	hubit	, no	2004	4

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $2^{\frac{\text{Day}}{7}}$ Akira Tomoyasu January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6636 Washington Boulevard # Elkridge Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Month, Day, Year) 10/15/1928 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 € M 2 □ F 575-24-6457 80 **Director** Eva, Hawaii Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Maxical Examinar mant be notified at Director 1 ☐ Yes 2 ☐ No Maryland Howard **Elkridge** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6636 Washington Boulevard#79 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1. Yes 2 No If Xes, Give ∠ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No 46-49 Specify: Specify:Japanese ð 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchant Marine U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matsutaro Tomoyasu Mitsu Yamamoto ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Naomi Tomoyasu - Daughter 10269 Bristol Channel, Elicott City, Maryland, 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/29/2009 Glen Burnie, Maryland 22. Name and Address of Facility Gary L. Kaufamn Funeral Home, Inc 21. Signature of Funeral Service Licensee 7250 Washington Blvd, Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHERO SCLEANIC CAMPIO MASCUCAL 451 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duis to (of as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 □Yes 2 🗆 No 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and tig e of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONATHAN COLUMBIA MO 4 1044 10700

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State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 02804

		1- For State Registrar	Certificate	of Death	Reg. N	lo.
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ledical Exami		Brenda Thor	npson		Month Day January 27, 2	nng <sup>Year</sup> 1435 hrs
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Funeral		Social Security Number     6. Sex	7. Age (In yrs. last birthday			M/DD/YYYY) 9. Birthplace (State or Foreign
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21215-0036 and be filed within 7 Mental Hygiene. marked other that event, the Medics	Be	Charles Th	ompson, Sr.	Rul	DU R	1665
213 Men Men mari	To	19a. Informant's Name/Relationship (Type,		ailing Address (Street and Number or	Rur oute Number.	, Cit or lown, State, Zip Code)
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Division of Vital Records, P.O.  To the Hospital or Attending Physician: The law requires that the within 24 hours after death  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacted.	Certification: To Be Completed by	Part II. Other significant conditions condi	tal: 1 Inpatient 2 ER/Outpat 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, (Specify) To the best of examination and/or invesmanner stated.  11 Medical Examiner 111 F	26.Place of Death (Chectient 3 DOA Other; Nurse of Injury 28c. Injury at Work?  1 Yes 2 No street, factory, office building, etc.  20ccurred at the time, date and place, as stigation, in my opinion, death occurred 29c. License number O.C.M.E.	1 Yes 2  24a. Was an autopsy performed Yes 2 Vek only one)  Sing Home 5 Res  28d. Describe how  28f. Location (Street or Town, State or Town,	No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No  sidence 6 Other: Scene injury occurred  et and Number or Rural Route Number, City  and manner as stated. place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00827 State of Maryland / Department of Health and Mental Hygiene Albert Tesch 2009 02805 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 28, 2009 Physician/ Year 1030 hrs Tesch Albert **Medical Examiner** William 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Linder 1 Year 6. Sex 5. Social Security Number **Funeral** Foreian Months Days Hours Min March 13,1944 Director 64 Vrs 1X M 2 393-42-9365 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location un 10b. County 10a State 1 X Yes 2 Baltimore 23a or 28a-f show notified at once. Baltimore rector 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number U.S.A. 21230 7 the 2818 Hindale Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nowith t 12. Was Decedent Ever in U.S. Armed Forces? Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Documented ion fewor Jo We must be or items Never Married 2 X Married Specify: White Yes 2 X No specify: Divorced If Yes, Give Year more MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after tent of Healh and Mental Hygiene.
nett of Healh and Mental Hygiene.
nett filem 27 is marked other than "natural", or nother tranumatic event, the Medical Examiner. Widowed à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 15-0036 U.S. Coast Guard Chief Warrant Officer 2 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Adeline Paulman Herman A. Tesch 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2818 Hindale Drive Baltimore, MD 21230 Mrs. Lou Ann A. Tesch/Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Feb. **Baltimore** Burial 2 X Cremation 3 Removal from State 2009 Glen Burnie, MD Atlantic Crematory Important: injury or oth Donation 5 Other Specify: 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services P.A. 1 2ND.Ave. Glen Burnie, MD 21061 MONZI Approximate Interval Implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or Between Onset and Physician failure. List only one cause on each line Death Medica a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a UNPENDED Item#1perME.as notated, G888, 2/3/09, WS the Hospital or Attending Physician: The law requires that the death certificate be entim 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia 23d. Date of delivery Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 V Unknown ğ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? ✓ Yes 2 1 1 Yes No page 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other; Other: Residence 6 examiner? Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 ✓ Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification Yes 2 No 1 V Natural Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 29, 2009 O.C.M.E.

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD

31. Date filed (Month, Day, Year)

FEB 0 3 2009

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 29, 2009 9:15 Ам Betty Vatenos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville Genesis Brightwood If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, DeC . 25, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** 1914 1 □ M 2 🛶 F 94 Greece 220-24-5464 Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. If hand Mental Hygiene. 77 Is marked other than "hatural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21237 USA 8703 Delegge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 0wner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fotios Fangikis Despina Demetriadis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other traum once. Michael J. Vatenos son 8703 Delegge Road; Baltimore, MD 21237 20a. Method of Disposition

1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2/2/09 Greek Orthodox Cem. Woodlawn, MD 4 Donation Other (Specify) 21. Signature of Fi 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Physician arter DYUNWW /Medical Due to (or as a consequence of): Examiner Dementie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner physician and the burial-transit The law requires that the death certificate be executed they server the Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 drsing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

68760, Box نه Division or Vital Records, or Attending Physician:

Vaterias

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 10

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month; Day, Year)

FEB 0 3 2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSLER HLRDAR

2. Registrar's Signature.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DRIVE

29c. License number

29d. Date signed (Month, Day, Year)

Bruce Francis Vas	1	Sr. State Registrar	of Maryland		artment of H tificate of D		id ivientai i		leg. No. 2 1	na noor
Physiciar	1/	Decedent's Name (First, Middle,La	st)					2. Date of Dea	ath	3. Time of Death
Medical Examine		Bruce Francis						Month January 3		1723 hrs
	ı	4a. Facility Name (if not institution, gi 1215 C Joppa Road	ve street and number)			oppa	Location of Dea	ith .	4c. County of Dea Harford	3(1)
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. Ia	-	f Under 1 Yea		_	rth(MM/DD/YYYY) 9. E	Birthplace (State or
Director		218-70-8578	X M 2 F	51	Yrs.	Months Day	s Hours M	oct 1	, 1957	Country) Maryland
any:		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Location					10d. Inside City Limits
* .		Maryland Harf	ord	.1	орра					1 Yes 2 X No
th the Maryland 23a or 28a-f she notified at once	Director	10e. Street and Number	J14			f. Zip Code			10g. Citizen of What Co	puntry?
h the N 3a or 3		1215 C Joppa Ro	ad			2108			USA	
ith with	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Armed Forces?				spanic Origin? ( n, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 14. Race - Am White, etc.	erican Indian, Black,
			1 Yes 2	X No	1 Ye	s 2 X No	specify:		Specify:	White
ours;af atural camin	<u>6</u>	15. Decedent's Education (Specify	Lor Dates:	pleted)	16a. Decedent's	Jsual Occupa			16b. Kind of Busines	
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5-0036 led within 72 Tygiène. other than the Medical	Completed	12 17. Father's Name (First, Middle, Las	n/a		<u>C</u>	hauffe I		me (First, Middle,	Transport Maiden Surname)	tation
21215-003 uld be filed with Mental Hygiene marked other th	ae Be	Norbert		Vasil			Lee	An	n Lock	ett
MD 21215-0036 of 2 should be filed within 7 fit and Mental Hygiene in 27 is marked other than turnatic event, the Median		19a. Informant's Name/Relationship				•			mber, City or Town, Sta	
- 한국 도로	-	Lee Ann Vasi1/Mot 20a. Method of Disposition	her	20b.	7 Dale			#203. Ti	monium, MD 20c, Location - City	21093 or Town, State
Baltimore, Normit, Pages I and Department of Heafti Important: If item Injury or other trau		1 Burial 2 X Cremation 3		ate	crematory or other	place)			G1 D	
Baltimore permit, Pages 1 Department of P Important: If injury or other	-	4 Donation 5 Other Special 21 Signature of Funeral Service Lice		At レ	lantic C:	remato: e and Addr <u>es</u>	ry 2,	/3/09	Glen Burn Dulaney Val	nie, Maryland
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Physician /Medical		23a. Part I. Enter the disease, or con failure. List only one cause on	each line						rest, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)	Atherosc Due to (or as a cons			ovascu	lar dis	ease ———		Death
Pare		Sequentially list conditions,	)	equence o						
	lue.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	f):		1.3			
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60, tte be e: hysiciar e burial	Medical	IF FEMALE:	23c. If yes, outcor					-	23d. Date of deliv	erv
Sox 6876( leath certificate e attending phy for use as the b	sician/ly	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal	death 3	Ectopic preg	gnancy	Month	Day Year
Box 687  death certification attending p	/SICI	1 Yes 2 No 9 Unknow	4 Pregnant at	time of de	eath 5 Other	(Specify)				
that the d	2	Part II. Other significant conditions		h but not r	esulting in the unde	erlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
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1 of Vi	:}	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2	28b. Time of Injur		ury at Work?		how injury occurred	lei. Scerie
on cending ath or: Af		1 X Natural 5 Pending	(Month, Day,)	ear)		1_	Yes 2 No			
Division of Vital Records, nator death or Attending Physician: The law require rs after death an Director: After this certificate has been sited in by the funeral director, page 2 should be not in the funeral director, page 2 should be a standard or the funeral director.	Certification;	2 Accident Investigat 3 Suicide 6 Could no	t be 28e. Place of Ir	jury - At h	ome, farm, street, f	actory, office	building, etc.	28f. Location or Town,		Rural Route Number, City
Di spital hours a meral I		4 Homicide determine 29a. Certifier 4 Continue Physics	(0,000)							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examin	er:On the basis of exa	y knowled mination a	ge, death occurred ind/or investigation	at the time, o in my opinio,	late and place, a n, death occurre	and due to the cau d at the time, date	ise(s) and manner as st e and place, and due to	tated. the cause(s)
	Me	29b. Signature and title of certifier	and manner stated.				se number		29d. Date signed (A	
		The 1 14	K.	200	an	0.0	.M.E.	OCME	January 31, 20	09
	t	30. Name and address of person who				1 Dans C	troot Delti-	oro MD 0400	11	
1		Theodore M. King, Jr., M			Examiner 11		u eet, baitim	JIE, IVID 2120	· · · · · · · · · · · · · · · · · · ·	
Sta Registr	91	31. Date filed (Month, Day, Year)	Q Wassing		parks					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G888, 2/3/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year WHEATLES THOMAS RAYMONID 2:15 JAN 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NIA UNION MEMORIAL HOSPITAL 8. Date of Bi 1/28/194/Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 **3** M 2 □ F Hours 212-40-420 65 Director 2009 MARYL Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Even it are must be notified at 1 Yes 2 No Director BALTIMORE MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? SUITE 500 21201 11.5 2 N. CHARLES ST. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: BLACK þ Specify 3 ₩ Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE LABORER CONSTRUCTION COMPANY permit. Pages 1 and 2 should be filk Department of Heatth and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) UNKNCいいい 18. Mother's Name (First, Middle, Maiden Surname) しん Kいこいん Be ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONY WHEATLEY JR. CRANDSON TOR NEWINGTON AVE., BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM. PARK DO/06/2009 BALTIMORE, MARYLAND 22. Name and Address of Facility

505EPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses illiamo 2140 N. FULTON AVE, BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE **Physician** BULLOUS 10 YEARS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SEPSIS be executed DUE 10 PNEUMONIA burial-tran Due to (or as a consequence of) 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death atte 3 Ectopic pregnancy ò in the past 12 months? Year Day 5 Other (specify) signed by the a o. 1 ☐ Yes 2 ☐ No. 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Des 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate of Vital I 2 MNo 1 ☐ Yes 2 🗷 🗸 🗸 o 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred Division 1) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kamkulkami, MD 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

RANI KULKARNI

FEB 0 3 2009

31. Date filed (Month, Day, Year)

UNION

32. Registrar's Signature

Clerana

MEMORIAL HOSPITAL, MO

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Cortificate of Death

			1 _ State	e of Maryland / Dep	partment of He e <i>rtificate of D</i>		ygiene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	erillicate of L	2. Date of D	Reg. No. 20	9 3. 4 me of beath 9
	Physici /Medic	an	Katie Mae Womble			Month	10 7	ear 5:10 QM
	Examin	-	4a. Facility Name (If not institution, give street ar	_ '	4b. City, Town, or I	ocation of Death	4c. County of	
			Bon Secours Hospit  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Baltin	Nore If Under 24 Hrs. 8. Date of B	N/A	. Birthplace (State or Foreign
в	Funeral Director		242-24-6061 1 M 25		Months Days		Day, Year)	Country)  NC
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	Aaryla f shov ed at	ō	MD N/A	Baltimo				1 TYYes 2 No
	r 28a-i notifi	irect	10e. Street and Number		10f. Zip Code		10g. Citizen of Wha	at Country?
	ith witl 23a o ust be	ral D	1315 Myrtle Avenue	:	212	17	USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Fleath and Mental Hygiene. Iterath and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by Funeral Director	1 Never Married 2 Married 1 If Ye	Yes 2 XNo es, Give r or Dates:	1 ☐ Yes 2 🙀 No	panic Origin? (Specify Yes or N , Mexican, Puerto Rican, etc.) Specify:	A	American Indian, White, etc. Irican merican
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712	d within giene.	Completed	Elementary/Secondary (0-12) Coll		estic Eng		Priva	te
Maryland 2	should be filed a and Mental Hygid s marked other a umatic event, tt	To Be C	17. Father's Name (First, Middle, Last) Ned Rudd			18. Mother's Name <i>(First, Middl</i> Mary Rudd	e, Maiden Surname)	
<b>Jan</b>	2 sho and r is ma		19a. Informant's Name/Relationship (Type. Print	' .	-	nd Number or Rural Route Num		, , , ,
	s 1 and 2 of Health Item 27 other tr		Betty W. Whitfield 20a. Method of Disposition	20b. Place of Disc	position (Name of	Date	20c. Location - Cit	
mo	Pages nent of I ant: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State King M	ematory or other place em. Park	2/7/09	Balt. C	ounty,M <sub>D</sub>
Baltimore,	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licensee		22. Name and Address 5126 Bela	of Facility Air Rd, Balt.	Close F. MD 2120	Svs PA 6-5105
90,	Physician /Medical Examiner bhysician and physician and the priral-transit the priral-transit physician and the priral-transit physician and the physician a	l Examiner	So, us fally list on Tile is if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of):  ue to (or as a consequence of):  ue to (or as a consequence of):  ue to (or as a consequence of):	tic Card	Liovasculu D	1202	Approximate Interval Between Onset and Death
.O. Box 68760,	eath certif attending for use as	Physician/Medical	in the past 12 months?		i⊟Ectopic pregnancy		23d. Date o	
rds, P	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contribution	to death but not resulting in the	underlying cause giver		tobacco use contribu ]Yes 2□ No 3	ute to the cause of death?  Probably 4 onknown
Il Records,	The lar ate has page 2	Completed				24a. Wa aut per 1 Yes	opsy price dea	re autopsy findings available or to completion of cause of th?  Yes 2 No
Vital	Physician: Th this certificate ral director, pac	Be	25. Was case referred to medical examiner?  1		Othor	26. Place of Death (Check only		
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ion	Attending r death. ector: Afte	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		es 2 □ No		
Division	l or Attendafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
L	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier Certifying Physician:	To the best of my knowledge, dea	ath occurred at the time	e, date and place, and due to th	e cause(s) and mann	er as stated.
	he Ho: n 24 h he Fur pletely	ledical	(Check only 2 Medical Examiner: On	the basis of examination and/or manner stated.				
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	e m	29c. License	number	29d. Date signed (/	Month, Day, Year)
			" hogs A	111	リリル	+1401	1/30/	109
1			30. Name and address of person who complete:	d cause of death (Item 23a) (Type 32. Registrar's Signature	Eu Tau S	t. Baltim	u MD	12/201
	Sta Registi		FEB 0 3 2009	ren A. gar	Kal			

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		State Registrar  1. Decedent's Name	e (First, Middle	e, Last)			Ce	rtificate (	of Dea	ath		Reg.		00!		28 e of Death
hysician /Medical	_	Joan Fl	orence	Wightma	an			-			JANL	JARY	Day	Year 200	ð9 11	: 59F
xamine	_	a. Facility Name (I		n, give street an philiped		Cent	ter	4b. City, Tow	vn, or Locat	man 20	th SON		4c. Count		th Ltimo	re
neral ector		5. Social Security N 212-40-5 Usual Residence of	055	6. Sex 1 □ M 2 <b>X</b> □		67	st birthday) Yrs.	If Under 1 You Months Da	ear If Ur ays Hou	nder 24 Hr urs Min	8. Date 3/29	of Birth th, Day, Ye /1941	ar)	9. Bir Co Mai	thplace (Sta ountry) rylanc	te or Foreig
Mor.	ŀ	10a. State	10b. County			10c. City,	Town or Lo	cation							10d. Insid	e City Limit
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Examinar must be notified at once.  To Be Completed by Europeal Directors	SCIO	MD	Balti	more		Timo	onium								1 🗆 \	res 2∏N
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eveni eveni	n i	17. Father's Name ( Vernon	(First, Middle, Eisner	Last)						Mother's Na rma (	me (First, M	liddle, Maid	den Surna	me)		
marke matic		19a. Informant's Na		hip (Type, Print)	)		19b. Mailir	ng Address (St				Number Ci	tv or Town	State	Zin Code)	
27 is er trau		Joseph T			,			Dickens					-			
r othe	2	20a. Method of Disp		3 ☐ Removal f	irom State	20b. Plac	ce of Dispo	sition (Name o	of r place)		Date	20c	. Location	- City or	Town, State	•
jury o		4 □ Donation			rom State	Dula	•	/alley		1	3/2009				Maryla	nd
any in		21. Signature of Fu	neral Service	Licensee	1	9		Name and A			owson					lo a d
ician dical		shock, or hea Immediate Cause ( disease or condition resulting in death)	(Final		on each line		apni	(D)   Y   1							Onset a	Between nd Death
niner	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions, mediate rlying injury ast	b c	e to (or as a	a conseque	nce of):	HL IN	FARC	TION						
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			Registrar	/F* . 4 . 8 . 4 . 1 . 1	4)		Cer	tificate of	Death	<u> </u>		Reg. No	-2009	02811	
	sicia edic		Decedent's Name (First, Middle, Last)     Margaret Ada					ckless			Feb. 2, 2009 ear 11			3. Time of Death	
Exa	mine	er	4a. Facility Name (If	notinstitution, give Ll Geria		,		4b. City, Town, o					c. County of Deat		
Fune	ral		5. Social Security Nu			7. Age (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Bir			hplace (State or Foreign	
Direc			212-78-	2191	□м 2Д F	88	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 5 – 29 –	2°0	Mar	yland.	
and w .		ŀ	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	cation			_			10d. Inside City Limits	
Maryli -f sho	2	ŗo	MD	Baltimo	ore	M	iddle	River						1 □ Yes 2 XNo	
h the		Director	10e. Street and Num					10f. Zip Code					itizen of What Co	L	
ath will		ra D	1300 V	Vindlass				2122					S.A.		
partition (e.) Intal yialing A.I.A. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21 is marked other than "natural", or items 23a or 28a-f show any Influctor of the trainmarts worth the Machical Examinar must be notified at		by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☑ Widowed		12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or Do	2 <b>⊠</b> No ∕e	1	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 1 No	lispanic Or an, Mexica Specify:		city Yes or No Rican, etc.)	)-	14. Race - Ame Black, White Specify: Whi	e, etc.	
172 h "natu		letec	15. Decedent's Education (Specify only highest grade completed)				16a. Deced	ent's Usual Occup kind of work done OO NQT use retire	oation during mos	st of workin	g	16b. h	Kind of Business/Industry		
withir lene.		Completed	Elementary/Secondary (0-12) College (1-4or 5+)				Home	maker	a)		owr			n hone	
other		Be C	17. Father's Name (				1		18. Mothe	er's Name	(First, Middle,	, Maidei	n Surname)		
Vial Suld b Menta arked		2	Evano	aro 	re	mpero		Anna			Fandenase				
and 2 sho ealth and n 27 Is m			19a. Informant's Na Ann And	me/Relationship (7 derson -	ype. Print) - daug	hter	19b. Mailin 4005	g Address (Street	and Numb Roa	er or Rural d Mi	Route Numb	er, City R <b>iv</b>	or Town, State, 2 er Md.	Zip Code) 21220	
mit. Pages 1 apartment of He portant: if iten				osition □Cremation 3 □ 5 □ Other ( <i>Specif</i> y		State 20b. F	Place of Dispos cemetery, cren Vete:	sition (Name of natory or other place rans Ce	ce) M •	2-9-	2009		ocation - City or ings, A	147	
permit. Departr	ouce.		21. Signature of the	peral Service Licen	see		- 22 J 2	Name and Address Name and Nam	ss of Facili Za	nnin ing	o Jr. St. B	Fu	neral :	Home 21224	
			23a. Cart1. Enter the	e dise de, i r comp failure. Lit only o	olications that cone cause on e	aused the deat ach line.	h. Do not ente	er the mode of dyin	ng, such as	cardiac or	respiratory a			Approximate Interval Between	
Physici		Ì	Immediate Cause ( disease or condition resulting in death)	inal	a	Adm	on 6	d D	Runa	mha	۸ .			Onset and Death	
/Medic Examir	_		resulting in death)		Due to (	Due to (or as a consequence of):									
G:		Je.	Sequentially list con if any, leading to im- cause. Enter Under	nditions, mediate	b. Due to (	or as a conseq	uence of):						,		
scuted nd ransit		Examiner	Cause (Disease or in that initiated events resulting in death) La	niury											
icate be executed physician and the burial-transit	3	Ĕ	resulting in death) L	ast	Due to (	or as a conseq	uence of):								
ficate physics the state		edical		_	d										
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I from many 2 should he detached for use as		Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 Live b	come pf pregna sirth 2  Feta ant at time of d own	Ideath 3□	Ectopic pregnanc Other (specify)	у				23d. Date of del Month	ivery Day Year	
v requires that been signed by		þ	Part II. Other signifi	icant conditions co	- 11	eath but not res		derlying cause giv		l. `	23e. Did t		use contribute to	the cause of death?	
aw rec		Completed	A.S	C.V.D	V						24a. Was		24b. Were au	itopsy findings available	
The i	200	E O									autor perfo	psy ormed? 2 N	death?	completion of cause of	
clan: ertific		Be	25. Was case referre	· -	1414-1-					e of Death	(Check only o				
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nding Iff.		tion	Natural 2 ☐ Accident	5 Pending investigation		th, Day Year)	Injury	Wor	k? Yes 2□		ou. Describe i	riow iriju	iry occurred		
To the Hospital or Attention within 24 hours after death of the Funeral Director:		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Place	of injury - At hong, etc. (Specif	ome, farm, stre	eet, factory, office		28	8f. Location (8 City or Tox	Street a wn, Stat	nd Number or Ru e)	ural Route Number,	
spitai lours a nerai			29a. Certifier	1 Certifying Phy	ysician: To the	best of my kno	wledge, death	occurred at the ti	me, date ar	nd place, a	nd due to the	cause(s	s) and manner as	stated.	
the Ho in 24 h the Fu		Medical	one)	2 ☐ Medical Exam	and man	asis of examina ner stated.	tion and/or inv			ath occurre					
P With	8	2	29b. Signature and t	MD				29c. Licens	38	75			ate signed (Monti	h, Day, Year) - 2009	
5			30. Name and addre	ess of person who	completed caus	e of death (Item	23a) (Type, F	PAST	BRI	4	BLU	D.	MD.	-21221.	
Reç	Stat jistra		31. Date filed (Monta	h, Day, Year)	32. A	egistrar's Signa	ture par	Kal							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** James Wright Sr. 02 01 2009 7:00a. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4516 North Rogers Ave Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours 62 Director 218-42-5517 09 10 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 √Yes 2 No Director MD NA Baltimore 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 4516 North Rogers Ave Funeral 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√2 No Specify <u>م</u> Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd 2 should be filed within th and Mental Hygiene.
7 is marked other Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Driver Moving & Storage Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked of any injury or other traumatic ew ပ Vern Wright Carrie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Essie Mae Wright-Wife</u> 4516 North Rogers Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2/7/09 Woodlawn, Md 21. Signature of Funeral Service Lincensee 22. Name and Address of Facility Thompson March F/H West 4300 Wabash Ave, Baltimore, Md Jume 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophageal **Physician** cancer months /Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No certificate 1 □ Yes 2 No Be ( 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be exec Box 68760. 98 Ö σ, Records, The of Vital To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this nontified Division

Maryland 21215-0036

Baltimore,

State

DHMH 17 Rev 1/2001

Wedical

29a. Certifier (Check only one)

150 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice 838

32. Registrar's Signature

parke

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Baltimore, MD

29d. Date signed (Month, Day, Year)

			1 - State Registrar		Ce	rtifica	te of i	Death			Reg. No. 2	nna	0281
	Physici	an	1. Decedent's Name (First, Middle, Last)  Charles Wilbert W:	Wilmouth						2. Date of Death Month Day Year 180			
	/Medic		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Deat		180 J M
	Examin	ıer	Union Memorial Hospital			Baltimore Ci				v	40. 000.	N/A	
4.00	Funeral		-	e (In yrs. la	ast birthday)		er 1 Year	If Under	24 Hrs.	8. Date of Bi	rth	9. Birthp	place (State or Foreign
	Director		218-36-2717   ¹¼☐ M 2☐ F	69	Yrs.	Month	Days	Hours	Min.	(Month, D Nov. 2	ay, rear) .8, 1939	Couir	irginia
	P.		Usual Residence of Decedent										
	show	-	10a. State 10b. County	10c. City	, Town or Lo	cation						1	0d. Inside City Limits 1 □Yes 2 No
	8a-f	Director	Maryland Anne Arundel Co.	(	Glen B								
	/ith th		10e. Street and Number			10f. Z	ip Code				10g. Citizen o	f What Cour	ntry?
	s 23e	era	1201 Leonard Drive	5 i- 11 6	140	M/ D	- demb of LI	21060		:4.3/		ed St	
	item item	Funeral	11. Marital Status  12. Was Decedent Armed Forces?  1 □ Never Married   12. Was Decedent Armed Forces?  1 □ Yes 2 2		5. 13.	lf Yes, sp	ecify Cuba	an, Mexicar	n, Puerto R	oify Yes or No lican, etc.)	0-   14. F	ace - Americ lack, White, o	
5-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be medified at	by F	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	NO		1 □Yes	Ž∏No	Specify:			Spe	oity: Wh:	ite
ş	2 hou	ed	15. Decedent's Education		16a. Dece	dent's Us	ual Occup	ation			16b. Kind of	Business/Inc	dustry
212	hin 72 e. an "nal	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or !	i+)	(Give life.	kind of v DO NOT	ork done d use retired	during mos d)	t of workin	g			
77	filed within Hygiene. wher than "	5	12 yrs.	.,		Dies	el En	gine				motiv	e
2	be file	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle	, Maiden Surn	ame)	
<u>X</u>		ဥ	Raymond Ray Wilmouth						Els:	ie De	lle Ro	berts	on
Maryland	2 sho		19a. Informant's Name/Relationship (Type. Print)			3					per, City or Tov	, ,	
	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		Mrs. Sharon A. O'Neil/Daugh	_				Road			m, Mary		21090
0	0, 0		20a. Method of Disposition 1 ÅBurial 2 □ Cremation 3 □ Removal from State		ace of Dispo emetery, crei				Da		20c. Locatio		
≣	t. Partmer tant:		4 ☐ Donation 5 ☐ Other (Specify)	Mea	dowrid								aryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	01121									emation
			23a. Part1. Enter the disease, or complications that caused									Surnie	,MD 21061
			shock, or heart failure. List only one cause on each li	ne.							arrest,		Interval Between Onset and Death
er ye	Physician /Medical		disease or condition a. SEUS			306	10	HCI	200	5/5			2 DAYS
	Examiner		Due to (or as	a consequ	ence of):	_ `		200	110	-			30A45
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequ	ence of):	DND RENAL FAIL  OSCLBROSIN / CORON							
	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	HCO	20 50							N Bry DISSE	
'n	an an rial-tr		resulting in death) Last Due to (or as	a consequ					/			7.70	
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X Ex	ing ph	Med	IF FEMALE:										
ô			23b. Was decedent pregnant in the past 12 months?	2 Fetal	death 3		pregnanc	у				23d. Date of delivery  Month Day Year	
	the a	Physician	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	t time of de	eath 5[	Other (	specify) _					no-tai	Day 10 a
ב	law requires that the death cer as been signed by the attendir 2 should be detached for use		Part II. Other significant conditions contributing to death b	ut not resu	Iting in the u	nderlying	cause giv	en in Part I		23e. Did	tobacco use co	ntribute to the	ne cause of death?
g,	signe d be	d by			3	, ,	3			10	Yes 2 No	3☐ Prot	pably 4 ☐ Unknown
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ā			25. Was case referred to medical					00 Dia	( D 4h		2 No	1 🗆 Yes	2 No
Division of Vital Records,	Physiclan: r this certific ral director, I	o Be	examiner?	ent 2 🗆 s	ER/Outpatie	nt 3 🗆 I	Oth	or:		(Check only	idence 6 □C	thor (Cassil	5.1
0	ding Phys th. After this funeral dir	n: To	27. Manner of Death 28a. Date of Inju	ıry	28b. Time o		28c. Injur Worl				how injury occ		у)
<u>0</u>	Attending ir death. ector: After by the funer	atio	1 Natural 5 □ Pending (Month, De 2 □ Accident investigation	iy, rear)	Injury	М		K? Yes 2□	No				
N S	Atte	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Initial building, el	ury - At hor	me, farm, str	eet, facto	ry, office		28	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
5	tal or s afte al Dir ed in	Certification:	- Individue Sanding, C.	c. (opcony	/					Only of 10	wii, Otate)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only 2 Medical Examiner: On the basis of	of examinat	vledge, deat ion <i>a</i> nd/or ir	h occurre vestigati	d at the ti	me, date ar pinion, dea	nd place, a ath occurre	nd due to the	e cause(s) and , date and plac	manner as s e, and due to	stated. the cause(s)
	the I	Med	one) and manner st	ated.						T			
	5 <u>8 § 6</u>		29b. Signature and title of certifier  M A					e number	•		29d. Date sig		0, 2009
	_						in in the Re-			E0			,
10	7		30. Name and address of person who completed cause of o	ieath (Item	23a) (Type,	Print)	BA	7. 14.	W C	MA	12	218	J (F.)
	≪ Sta	ite	31. Date filed (Month, Day, Year) 32. Registr	ar's Signat	ure Ann	Ked	13/10	. 17.00	-	7 1 4	- E	~ 13	
	Registr		30. Name and address of person who completed cause of of SACIM RIZE MD  31. Date filed (Month, Day, Year)  FEB 0 3 2009  32. Registr	, p.	7								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Tyashean Tavone Washing 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Medica sultimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreig Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Min 1 XM 2□ F Director NIA 26 01/22/2009 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show the notified at 28a-f show 1 Yes 2 No Director BALTIMORE MO BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21216 SA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medica Examiner must I 1433 Cour by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA NIA 0 NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margares Tavore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery crematory or other place) Adlean Washington Inothe Mor Court Baltimore MD 21216 20c. Location - City or Town, State 20a. Method of Disposition ND Bunal 2 □ Cremation 3 □ Removal from State Date BALTIMORE athedra UNKDOWN 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility willow Spring RD F.H. Ph BRADLEY ASHRA resail MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician weeks aestation 2h. 21emin Extreme Prematurity disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physiclan Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 3 ☐Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate is 2 **Y**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

cal

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

Amanda Bur TON

FEB 0 3 2009

DHMH 17 Rev 1/2001

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

NPI: 1942332408

301 St. Paul Place Baltimore, City

29d. Date signed (Month, Day, Year)

01/22/2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Рм **Physician** January 28 Shirley Ann Youngs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randalistown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2 TF 096-32-2400 Director 67 11/27/1941 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County show ed other than "natural", or items 23a or 28a-f showevent, the Wedloal Evanthar nust be notified at 1 ☐Yes 2 ☐ No Windsor Mill Director Baltimore M with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21244 18 Rhonda Court Completed by Funeral filed within 72 hours after death 1 I Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ZNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: 3N Widowed 4 □ Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mercy Hospital Dietary Supervisor 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 Is merked othe eny linjury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) Be Clara Hubbard James Tyler ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 Rhonda Court Windsor Mill, MD 21244 Gail McField / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Port Washington, NY Nassau Knolls Cametery 2/5/2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Cilensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. (C). 9200 Liberty Road Randallstown, MD 21133 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Uterine **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physicien; The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, Completed by 2 No 3 Probably Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☎ No 24a. Was an certificate has trector, page 2 s autopsy 1 ☐ Yes 2 🔼 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 🖻 Natural To the Hospital or Attendin Awithin 24 hours after death. To the Funerel Director; Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baitmore Mis 2835 Smith Burton berah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. filled in by the funeral death.

Baltimore,

Hospital or Attending Physician: To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number

29b. Signature and title of certifier

027730 2/1 WAKES IT. BANTINO

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 3 2009

6569

32. Registrar's Signature Laura

Medical

(Check only one)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1-17-2009 Day **Physician** 11:00 A M Ellery B. Ballou /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Lorien Nursing Home Columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min **№** 2 | F 91 12-28-1917 TXDirector 453-20-8780 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Item Worlden Evan, Item to nother traumatic event, Item Worlden Evan, Item to nother traumatic event. 1 ☐ Yes 2x No Director Elkridge Howard 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21075 8109 Sunrise Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Tyyes 2 □ No f Yes, Give 10 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942-45 1 □Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway 12 Oil Pumper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy E. Baker James R. Ballou ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8109 Sunrise Lane, Elkridge, MD 21075 Elladean Brigham / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-21-2009 | Elkridge, MD Meadowridge Mem. Pk. 22. Name and Address of Facilit Harry H. Witzke's Family FH, Inc. Juneral Service Mo1411 M 4112 Old Columbia Pike, Ellicott City, MD 21043 Approximate Interval Between Onset and Death br complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Hater the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final hours urosepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obet month urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine foley catheter law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 **N**o 1 □ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 Cinson Attending Physician: . Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 ☐Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.
To the Funeral Director; A completely filled in by the fu death. investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

Gedar lane #103 Columbia MD 21044 Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334 se cca e 1. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State		State o	f Marylai								0000	02010
			Registrar  1. Decedent's Name	Timeat	tificate of Death Reg. 2. Date of Death					2000	3. Time of Death				
^	Physici		Daniel S					Januar	U 17 2009 2102 M						
	/Medio		4a. Facility Name (I	4b. City, Town, or Location of Death 4c. County of Death					th						
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	Funeral		<ol><li>Social Security N</li></ol>	lumber 6. S		7. Age (In yrs	. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12/16/	rth ay, Year	9. Birt Co	thplace (State or Foreign ountry)
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36	s afte	oy F	1 ☐ Never Marri 3 ☐ Widowed	ried 2 Married	1 [XYes If Yes, Gi Year or D		983	1 □Yes	2 <b>X</b> No	Specify				Specify: W	hite
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Benchoff, Daniel Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mariel Expriber or at be notified at once.			uneral Service Lice						ss of Facil	ity Tfanl	pain Fu	nors	al Home	
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و ا	v require been sig	Completed										24a. Was	s an	24b. Were a	utopsy findings available
a a	he law te has	l E										_ perf	opsy formed? 2 1 N	prior to death?	completion of cause of s 2 □ No
<u> </u>	sician: The la certificate ha	Be C	25. Was case refe	rred to medical	Ī					26. Plac	ce of Deat	1 ☐ Yes th (Check only		10 1 10 10	5 2 110
<u> </u>	Physici this cer al direct		examiner? 1 ☐ Yes 2 🛣	ĴΝο	Hospital: 1	Inpatient 2	☐ ER/Outpation	ent 3É(D	OA Oth	er: 4 🗆 N	lursing Ho	ome 5 🗆 Res	sidence	6 ☐ Other (Spi	ecify)
	ding Ph h. After th funeral	l E	27. Manner of Dea	ath 5 Pending	28a. Date (Moi	e of Injury nth, Day, Year)	28b. Time Injury		28c. Injui Wor	k?		28d. Describe	how inj	ury occurred	
i	tendii eath. or: A	cati	2 ☐ Accident 3 ☐ Suicide	investigation				М	1.0	Yes 2	]No	no. I w			
Division of Vital Becords	or Att	ŧ	4 ☐ Homicide	determined	28e. Place build	e of Injury - At ding, etc. (Spe	home, farm, s cify)	treet, factor	y, office			City or To	(Street a own, Sta	and Number or F ite)	Tural Route Number,
() C	pital Durs a eral (	ပို့	29a, Certifier	12 Certifying P	hvsician: To th	ne best of my k	nowledge, dea	ath occurre	at the ti	me, date	and place	, and due to th	e cause	(s) and manner a	as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To	(Check only one)	2☐ Medical Exa	miner: On the and ma	basis of exami	nation and/or	investigatio	n, in my	opinion, de	eath occu	rred at the time	e, date a	nd place, and du	e to the cause(s)
	To the within To the comp	Me	29b. Signature an	d title of certifier	2		10	29	c. Licens	e number			29d. E	Date signed (Mon	th, Day, Year)
			10	ON	Jus	La	101	1	1	13	762	2	6	71.19	7
	7		30 Name and add	dress of person who	completed cau	use of death (It	em 23a) (Type	e, Print)	^	,	^		2 _	2// 21	
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	St Regist	tate trar	31. Date filed (Moi	dress of person who with Day, Year)	19 Sen	negistrar's Sig	g. pa	Mar							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Am<u>ended#5</u>\_18 1-Certificate of Death Reg. No. 1/22/09, MS 2. Date of Death ecedent's Name (First, Middle, Last) Year Month Physician seward anuary ,200 /Medical 4c. County of Death City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Kent (enter nester town Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 T F Months Days Hours MARYLAND JAN 14. Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo MD QUEEN ANNE'S MILLINGTON 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number ō death with items 23a 204 PFALZGROFF ROAD 21651 USA - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itei 1 ☐ Yes 2 ☐ No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: Baltimore, Maryland 21215-0036 Specify. WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 8 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 ALLIE SEWARD GRACE JARMAN Teat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CINDY MCCLAIN/DAUGHTER 208 PFALZGROFF ROAD MILLINGTON, MD 21651 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MILLINGTON ASBURY 01/16/2009 MILLINGTON, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Dit 130 SPEÉR ROAD CHESTERTOWN MD 21620 Approximate Interval Between Onset and Death 23a. Part1. Enter the dise shock, or heart failure. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complic Immediate Cause (Final hronic Obstructive 5 4 cars **Physician** disease or condition resulting in death) /Medical Examiner Kengivatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Diecase of injury that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Intersthal F. Frosis 2 No 3 Probably 4 Unknown Completed a diovasculos D. 3 col 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 22No Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar

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Ditretorn Mil 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

516

trar's Signature

Ross, MP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra/Amend#26.PerPhys.PGC1-21-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 12, 2009 Elizabeth Physician Florence Belt 11:30 P.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Capitol Heights Prince George's 448 Shady Glen Drive 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 5. Social Security Number 6 Sex Min. **Funeral** Days 01/26/1933 Wash., D.C. Months Hours 1 M 212 F 578-28-9972 75 Director Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 □ No la or 28a-f sh t be notified a Director Prince George's Upper Marlboro Md. death with the 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1077 Largo Road 20774 U.S.A. items 23a must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etc.
African other traumatic event, the Medical Examiner 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2X No Saltimore, Maryland 21215-0036 Specify American þ 3 ₩Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f and 2 should be filed within ' lealth and Mental Hygiene. Im **27 is marked other than "** Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Allen Samuel Flood ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William A. Belt/Son 905 Minna Avenue, Capitol Heights, Md. 20743 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If its any injury or o tX Burial 2 ☐ Cremation 3 ☐ Removal from State 01/21/09 Harmony Mem. Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Namaans Addas Mington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NCReat 1c Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if am leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectonic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 ∰Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy 22 No certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 52 Residence 6 Nother (Specify Residence 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 2 No 2 this 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred funeral 28c. Injury at Work? Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Af of in by the full 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide

Hospital or Attending Physician:

filled in by To the Hospital within 24 hours ar To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) Alt SE

29d, Date stoned (Month, Day, Year)

8926 Woodyard Road, # 101, Clinton, Maryland 20735

State Registrar

32. Registrar's Signature Dat 15 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month **Physician** 01-11-2009 2:40P M Daryl Elbert Beard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Temple Hills 2305 Dawson Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 36 Months 1**X** M 2□ F 216-08-4475 Wash, 03-31-1972 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle r than "natural", or items 23a or 28a-f ehov the Medical Examinar must be notified at Prince George's X□Yes 2□No Temple Hills **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 20748 U.S.A. 2305 Dawson Street 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Probation Officer C.S.O.S.A. Ith and Mental Hyur 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked c any lojury or other traumatic even page. Adaline Pipes Jesse E. Beard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2305 Dawson St., Temple Hills, MD 20748 Shannan Dudley-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/17/2009Clinton, MD Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pinckney-Spangler F.H. 23a. Part1. Enter the disease, or complications that caused the path Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - 524-8th St., N.E., Wash, DC 20002-5236 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2 YEARS ANGIOSARCOMA /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant or u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 24b. Were autopsy findings available prior to completion of cause of death? certificete has tirector, page 2 s 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1X Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 0 within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ish Vaian, MD, PhD

State Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

(them 23a) (Type, Print); Cut cet Cote 3800 Reservoir Road, NW Wash PC 2000)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $P^{\,\mathsf{M}}$ 01/12/2009 Grace Yvonne Creamer Bailey 6:52 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 84 11/14/1924 Director 234-30-9828 Huntington, WV Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show items 23a or 28a-f sho 1 Yes 2 □ No Director MD Prince George's Mount Rainier 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3143 Queens Chapel Road, #101 20712 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Vas Deceuc... \rmed Forces? □Yes 2 🔀 No Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar, once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🖾 No Specify Specify: 2 3 X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oswald Poret Creamer Grace Guyton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bailey Lawson / Daughter 2306 57th Place, Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/2009 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Subdural Hematoma (non-traumatic) disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Cerebral Vascular Accident Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) Box 68760. physician attending pl IF FEMALE: f yes, outcome of pregnancy □ □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☒ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 X Natural ה Hospins. In 24 hours after death. The Funeral Director: Af. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M D64561 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van Mai, 7600 Carroll Takoma Park, MD 20912 Avenue, Signature 31. Date filed (Month, Day ) 32. Registraris State Registrar

DHMH 17 Rev 1/2001

09-00544 Gary Bull Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iry Bull		- For State	e of Maryland / Depa <i>Cer</i>	rtment of Hea tificate of Dea		Reg. I	No. 20	00 0203
Physicia	an/	tegistrar  1. Decedent's Name (First, Middle,La	ist)	<del></del>	14.	2. Date of Death  Month  Danuary 19,	Veer Veer	3. Time of Death 1002 hrs
edical Exami		4a. Facility Name (if not institution, gi	ive street and number)	1 .	Town, or Location of Deat		4c. County of Death	
		Holy Cross Hospital	Sex 7. Age (In yrs. la		er Spring  der 1 Year   If Under 24Hr	s 8 Date of Birth (	Montgomery  MM/DD/YYYY) 9. Bir	thplace (State or
Funeral Director			M 2 F 53	Yrs.		. , ,	Foreig	ountry) DC
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th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	0	10f. 2	ip Code 2090 Z		Citizen of What Cou	ntry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygie with the Matryland. T's marked other than "natural", or items 23a or 28a-f she manic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.	.S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? ( S cify Cuban, Mexican, Puert	Specify Yes or No- o Rican, etc.)	White, etc.	ican Indian, Black,
us after o inral", o	à	Widowed 4 Divorce  15. Decedent's Education (Specify	ed If Yes, Give Year	16a. Decedent's Usu	2 No specify: al Occupation (Give kind of	work done	Specify: Spe	
136 hin 72 hou e. than "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		vorking life. DO NOT use re  Program et  18. Mourier's Nan		1A ADMI	nistration
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, Las	Bull			ne (First, Middle, Ma CAPPEN A		
212 hould be nd Menta is mark	To B	19a. Informant's Name/Relationship			ess (Street and Number of	Rural Route Number	er, City or Town, Stat	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Operamen of Health and Mental Hygiene Important: I filene 27 is marked other Unignry or other traumatic event, the Mec		Sue C. Bull  20a Method of Disposition	20b.	crematory or other pla	ce)	ì		
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Balt permit. Depart Impor	J. 1	(////	11 15	3005 1	2th ST NE W	ashinitan	DC 2001	
Physician i I	00 0	232. Part I. Enter the disease, or cor failure. List only one cause on	mplications that caused the death each line. a. <b>Hypertensive</b> a					Between Onset and Death
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687 ertifica ding p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pres  1 Live birth  4 Pregnant at time of d	2 Fetal de		nancy	23d. Date of delive	Day Year
, Box the death of y the atten	1 7	Part II. Other significant condition	9 GIIKIIOWII	resulting in the under	ring cause given in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
ords, P.O.    v requires that the s been signed by t should be detache			diabetes melli			1 Yes		obably 4 🗸 Unknown
of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should 1	Completed by	[				24a. Was ar autops perform	y prior to	
tal Rection: The Coertificate		25. Was case referred to medical			26.Place of Death (Che	1 Yes 2	✓ No 1	Yes 2 No
Vital   hysician: this certif	o Be	examiner?	Hospital: 1 Inpatient 2 ▼	ER/Outpatient 3	DOA Other Nur	sing Home 5 F	lesidence 6 Oth	ner:
ion of V tending Ph eath. tor: After ti	I =	27. Manner of Death  1 X Natural 5 Pending		28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division pital or Attendir ours after death. eral Director: /	Certification	2 Accident Investig 3 Suicide 6 Could r 4 Homicide	not be 28e. Place of Injury - At	home, farm, street, fac	tory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Di To the Hospital within 24 hours: To the Fineral	Medical C	29a. Certifier 1 Certifying Phys	sician: To the best of my knowle iner:On the basis of examination and manner stated.	edge, death occurred a and/or investigation, is	the time, date and place, and my opinion, death occurre	and due to the cause ed at the time, date a	(s) and manner as sind place, and due to	the cause(s)
Too Too	Me	29b. Signature and title of certifier	and manner stated.		29c. License number O.C.M.E.		29d. Date signed (A January 20, 20	•
10 1		30. Name and address of person w	ho completed cause of death (Ite			ND 04004		
M	State	Donna M. Vincenti, MD	Too Baristant Since	1100	nn Street, Baltimore,	MD 21201		
Regi	State		aura B. A	ralled				

OCME

			For	State of Maryla				lental Hy	giene 2 n n c	02824		
			State     Registrar     Decedent's Name (First, Middle, Last	1	Cer	tificate of I	Death	2. Date of Dea	Reg. No. CUU.	3. Time of Death		
Physician			LOMUN		130	ZIGANT	T	Month	Day Year	3. 7me of Death		
Inon	/Medic Examin		4a. Facility Name (If not institution, give				Location of Death	JANUA	4c. County of Dea	th 1		
-/			92 AVONDA	Le CIRCI	e		ENA P	ARK	1+NNR			
	Funeral Director		5. Social Security Number 6. 6e 231–62–6801	х 7. Age ( <i>ln )</i> Эм 2 <b>Д</b> F <b>85</b>	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da		thplace (State or Foreign		
			Usual Residence of Decedent	00				Feb. 20	) <u>, 1923 New</u>	Jersey		
	arylan show	<u>.</u>	10a. State 10b. County MD Anne Arur		City, Town or Loc Severna					10d. Inside City Limits		
	he Ma 28a-f	ecto	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	1 ☐ Yes 21 No		
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it a Medical Event is at the notified at e.e.	Funeral Director	92 Avondale Circl	.e		211	146		USA	ound y :		
	death ms 2;	nera	11. Marital Status	12. Was Decedent Ever in	1 U.S. 13. V	/as Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Am			
36	after or Ite		1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ∐Yes 2 M No If Yes, Give		Yes, specify Cuba	Specify:	nican, etc.)		<sub>e, etc.</sub> White		
21215-0036	hours tural",	Completed by	3 Widowed 4 Divorced	Year or Dates:					16b. Kind of Business			
215	n na	plet	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)							industry		
212	filed within Hygiene. <b>other than</b> "	E 0	Elementary/Secondary (0-12)	College (1-4or 5+)	Regi	stered Nu	ırse		Hospital			
Maryland	be file	æ	17. Father's Name (First, Middle, Last)  Stephen Nagy				18. Mother's Name Helen V		Maiden Surname)			
ryla	should be and Mental Is marked o aumatic eve	٩	19a. Informant's Name/Relationship (Ti	rne Print)	10h Mailin	Address (Street			er, City or Town, State,	Zin Coda)		
Ma	and 2 s ealth an n 27 Is I		Emidio Briganti/ h	•	1				ark, MD 211			
J.	ss 1 an of Heal item 2 r other		20a. Method of Disposition	20	b. Place of Dispos	ition (Name of atory or other place	Jan.	ate 12	20c. Location - City or	Town, State		
imo	Page ment ant; If ury or		1 ☐ Burial 2 ☐X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	ternoval from State	etro Cre	matory, I	INC. Danie	oóś <b>'</b>	Baltimore	, MD		
Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe		21. Signature of Funeral Service Licens	ee Yerler	Ba 49	Name and Addre	Sons, P.A itchie Hwy	A. Seve	rna Park Fu rna Park, M	neral Home D 21146		
			23a. Per 1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the d	eath. Do not ente	r the mode of dyir	ng, such as cardiac c	or respiratory a	rrest,	Approximate Interval Between		
-	Physician		Immediate Cause (Final disease or condition a. PNEUMONA 3W6									
4	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	- 5						
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):							
	cuted nd ransit	Examiner	Cause (Disease or injury	3.								
0,	ate be executed hysician and he burial-transit	Ë	resulting in death) Last	Due to (or as a cons	sequence of):							
8760	physic the b	dical		d								
9 xc	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of pre	gnancy				23d. Date of de	livery		
Box	death e atter d for u	iciar	in the past 12 months?	in the past 12 months?  1						Day Year		
P.0	at the de by the tached	hys	9 Unknown	9 🗆 Unknown								
	res tha signed be det	þ	Part II. Other significant conditions co	-	resulting in the un	derlying cause give	en in Part I.		obacco use contribute t			
Records,	w requir been s should	Completed		,				1 🗆 \	7	robably 4 Unknown		
Rec	: The law cate has t	du	HYPERTEN	-				24a. Was autop		utopsy findings available completion of cause of		
Vital	ician: Th certificate ector, pag		05760APTI	1721TLS			26. Place of Death	1		3 2 □ No		
f Vi	nysician: nis certific director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	3 □ DOA Oth	or:		dence 6 □Other (Spe	ecify)		
n of	ding Ph h. After th funeral	L:uo	27. Mannet of Death 1 □ atural 5 □ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injur Worl	k?	28d. Describe h	now injury occurred			
sio	Attending r death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	DO - Blace of luiting A	A la compa de compa et co		Yes 2 □No	206 11' 44				
Division	I or Attend after death Director: d in by the I	Certification:	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecity)	et, factory, office	'	City or Tou	Street and Number or R vn, State)	ural Houte Number,		
	Hospital or 24 hours afte Funeral Dir tely filled in			sician: To the best of my								
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only 2 Medical Exami one)	ner: On the basis of exam and manner stated.	nination and/or inv							
	vith To t	Σ	29b. Signature and title of certifier	11/1	Inn	29c. Licens	11001		29d. Date signed (Mon	1 > - March		
	60		· Mush	11-4	0001	ען ייייי	10 566		JANVARY	14, 144		
	1,00		30. Name and ddress of person who co	propleted dause of death (	item 23a) (Type, F	1 Votor	PANS HIE	Hinin	Marie	CIMO NO		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature		11/1	, ivit	Hallore 10	21/08		
عبينية.	Registr	ar	JAN 1 4 20	109 Jeneur	1. A	tike						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:20 am Briscoe Catherine 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death lata 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/1/1919 9. Birthplace (State or Foreign Country) 1 M 2 XF 89 Months Days Hours Min. 212-22-0466 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Charles Waldorf 10e. Street and Number 10f. Zip Code Citizen of What Country? 10g. Citiz 20602 5238 Piney Church Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2√☐ No Specify 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 6th Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearlie Grant Tom Coley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Battle/Daughter 5238 Piney Church Rd. Waldorf, MD. 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Buria! 2 ☐ Cremation 3 ☐ Removal from State Veterans Cem. 1/26/09 Cheltenham, MD. MD -4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00902 22. Name and Address of Facility Briscoe-Tonic Funeral Home - Benerici Conc 2294 Old Washington Rd. Waldorf, MD. 2060 -10 RIC 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 DUNO

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner

injury o

**Physician** 

/Medical

Examiner

10a State

MD

**Funeral** 

Director

28a-f show

items 23a or

Director

Funeral

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Completed

Be

traumatic event, the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "

Maryland 21215-0036

Baltimore,

sician and burial-trans the. signed if

w requires that the death certificate be executed

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5 Pending investigation

☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ma

1 Nnpatient

28a. Date of Injury (Month, Day, Year)

25. Was case referred to medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

examiner?

27. Mayr er of Death

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a, Certifier (Check only

one)

Examiner

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physiolan: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filed in by the funeral director, page 2 should be detached for use as the burian	
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State Registrar ente

2 ☐ ER/Outpatient 3 ☐ DOĂ

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medica

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Wilson Lorne Burton 7:35A M 16, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Feb. 3, 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number Age (In yrs. last birthday **Funeral** 346-20-6889 82 Feb. 1926 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show traumatic event, the Medical Exemplant cust be notified at Director 1 ☐ Yes 2 XNo Maryland Montgomery Clarksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ò 22929 Frederick Road 23a 20871 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or items 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White <u>Ş</u> 3 Widowed 4 Divorced WWII "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. United Methodist College (1-4or 5+) 5+ Elementary/Secondary (0-12) Clergy : 1 and 2 should be filed wi Fealth and Mental Hygier tem 27 Is marked other th Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lindsay W. Burton Irsel Echols ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : If item 27 Is or other tra 22929 Frederick Road, Clarksburg, Maryland 20871 Mary D. Burton - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Important: If it any Injury or c Burial 2 ☐ Cremation 3 ☐ Removal from State Neelsville Cemetery Jan. 22, 2009 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligansee Molesworth-Williams P.A., Funeral Home over 26401 Ridge Road, Damascus, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Days disease or condition resulting in death) Respiratory Failure /Medical Due to (or as a consequence of): Examiner Pneumonia 4 Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hemothorax 7 Days the buriel-trait resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) s been signed by the s 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2X No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D67986 1/16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuneng Li, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Months Day, 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health a  1 - State Registrar  Certificate of Death			0.0	2.0	00007
		4	1. Decedent's Name (First, Middle, Last)		Date of Dea	Reg. No. 2	09	3. Time of Death
线	Physici /Medic		Beverly Mae Breen	J	Month anuary	Day 17, 20	Year 109	12:57 Ам
,	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of the control of t	of Death		4c. County		
1	Funeral	nggi.	Calvert Memorial Hospital Calvert  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24 Hrs. 8.	Date of Birth	1		lace (State or Foreign try)
L	Director		218-34-7263	Min.	(Month, Day ugust 8	8, 1937_	Wash:	ington, DC
	and ww		Usual Residence of Decedent  10a, State 10b, County 10c. City, Town or Location				1	0d. Inside City Limits
	Maryl 1-f sho fied a	tor	Maryland Prince George's Brentwood					1⊠Yes 2□No
	ith the or 28s e noti	Jirec	10e. Street and Number 10f. Zip Code			10g. Citizen of V	/hat Coun	try?
	s 23a nust b	erall	4409 37th Street 20722	rigin? (Specifi	Vos or No-	USA 14 Bace	e - Americ	an Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No  If Yes, specify Cuban, Mexical  If Yes, specify Cuban, Mexical  If Yes, Sive  1 □ Yes 2 ☒ No Specify.  Year or Dates:		an, etc.)	Blac	k, White,	etc.
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Maryland	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number)				. ,	
	1 and Health sm 27 ther tr		Mary Estrada / Daughter 32 Robshire Manor  20a. Method of Disposition 20b. Place of Disposition (Name of	Road,		ngtown,		
altimore,	Pages nent of I ant: If ite ury or o		1 X Burial 2 Cremation 3 Removal from State	1/26/2		Brentwo		
Baltii	permit. F Departm Importar any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ity		4739 Ba	altim	ore Avenue
r			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.				71116	Approximate Interval Between
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287		edical	d					
Box (	that the death certified by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Dat	e of delive	ry Day Year
o.	the de	ysic	1  Yes  No 9 Unknown 4 Pregnant at time of death 5 Other (specify)					
Division or Vital Records, P.O. Box	g B	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	l.				ne cause of death? ably 4 □Unknown
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<u> </u>	The lay	Com				med?	death?	npletion of cause of 2 ☐ No
Zita Zita	nysician: Th nis certificate director, pag	Be	examiner? Hospital: Other:	e of Death (C				
ō	ding Phys 1. After this funeral dir	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ence 6 Oth		<u>/)                                    </u>
ion	tending Fleath. tor: After the funer	atio	2 Accident investigation M 1 Yes 2	]No				
N X	l or Atten after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier  (Check only one)  Check only one)					
	To the within ?	Mec	29b. Signature and title of certifier 29c. License number			29d. Date signed	i (Month,	Day, Year)
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2	3			DERI		CAD J	# 3	
	Sta	te.		OE KI	cic 1	اله د،	-6/	*
and the	Registr	-	31. Date filed (Month, Day, Year)  JAN 2 1 2009  32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25 State of Maryland / Department of Health and Mental Hygiene estrar per me g891,05/21/09dhb Reg. No. For A1 State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Thomas Preston Baker January 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1309 Aldino-Stepney Road Aberdeen Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min 1 X M 2 □ F 66 Director Nov. 8, 1942 Maryland 213-40-0190 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 28a-f sh notified Director 1 ☐ Yes 2 X No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or ms 23a 1309 Aldino-Stepney Road 21001 USA Funeral ortant: If Item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ⊠ Yes 2 □ No 1962— If Yes, Give Year or Dates: 1965 1 ☐ Yes 2X No Specify: <u>۾</u> Specify: White 3 Widowed 4 Divorced 1965 Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Nursing Assitant Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 is marked oth John Thomas Baker Myrtle Louise Tolley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Marie Baker (wife) 1309 Aldino-Stepney Road, Aberdeen, MD 21001 permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other? Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harford Memorial Gdns. 2/2/09 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** all /Medical Due to (or as a consequence of): Examiner CERTIFICATION AND PROVED BY MEDICAL VALVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of) physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No certificate has autopsy perform 2 No 2 NO 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Accident Injury 5 Pending investigation 2007 **Unknown**<sup>M</sup> 1 Yes 2 No Subject fell 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1309 Aldinofilled in by 4 Homicide Home Stepney Rd., Aberdeen, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director:

Registrar

DHMH 17 Rev 1/2001

DIC

State

29b. Signature and title of certifier

ov i 31. Date filed (Month, Day, Year)

367 Name and address of person who completed cause of death (Item 23a) (Type, Print

MD

32. Registrar's Signature

9

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 02829 For State Registra AMENDED #8 PER FH 1/26/09 Certificate of Death CCHD AS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 4:25 AM orence an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Cenk OF Baltimore University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8.03/28/1931 Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 Ϊ 🗓 K Director 219-28-2558 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Examiner out by notified at 1 Yes 2 □ No Director Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 464 Dutchman Lane Funeral 21639 S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>Homemaker</u> <u>Own home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev is marked ဥ John Baierlein Mary Gardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Benner/Daughter Academy Ave., Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial 4 Donation 5 Dother (Specify) 01/22/2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home 106 W. Sunset Ave., Greensboro, MD 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Muccandia /Medical Due (or as a consequence of): Examiner Sequentially list conditions, any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Physician/Medical Examl sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached 9 Unknown care has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 1 No 1 ☐Yes 2 ☐ No 1 ∐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitai within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 eena

Registrar

DHMH 17 Rev 1/2001

State

22 South Greene Street Balhimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Meena V. Shah, MD

JAN 2U 2009

31. Date filed (Month, Day, Year)

			7 & 19b Please Type or Print in Black high dept 1/14/09 John Maryland For AMEND#100PER FH 1/15/09 of Maryland 1-Registrar CMH AACO HEALITH DEPT.	/ Depa	artment of Health and Natificate of Death	/lental Hygi	iene g. No. 2009	02830
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Leslie Curry			2. Date of Death	h Nav Year	3. Time of Death 6:58 P M
-	Examir		4a. Facility Name (If not institution, give street and number) 3939 Bayside Drive		4b. City, Town, or Location of Death Edgewater		4c. County of Dea Anne Arui	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 153-26-7421		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, NOV 22,	9. Bir 1923 Eng	thplace (State or Foreign ountry) gland
	Maryland a-f show fled at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Maryland Anne Arundel Edg	Town or Lo				10d. Inside City Limits 1 □Yes 2 ▼No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 3939 Bayside Drive		10f. Zip Code 21037	10	og. Citizen of What Co	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, I'm Medicol Examination must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☐ No If Yes, Give 1 ☐ Yes, Give 1 ☐ Yes ar or Dates:		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ∐Yes 2 XNo Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit SpecifyWhit	e, etc.
Baltimore, Maryland 21215-0036	within 72 ho lene. <b>than "natu</b> i he Medical	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired) rsity Professor	ing   1	16b. Kind of Business	/Industry
land 2	uld be filed Mental Hygi irked other itic event, II	To Be Co	17. Father's Name (First, Middle, Last)  John Curry		<del>`</del>	e (First, Middle, N		
e, Mar)	and 2 sho fealth and l im 27 is ma her trauma			<del>3929</del> 3939	Bayside Drive	l <u>sewater</u> Edgewat	Md. 210; ter, MD 2	37 21037
imore	Pages 1 ment of H ant: If ite ury or ot		cen	etery, ciei P1ea	natory or other place) sant Cemetery 01/1	14/09	oc. Location - City or Ontario, Ca	anada
Ball	permit Depart Import any in		21. Signature of Funeral Service Hoenses	22	2. Name and Address of Facility Geo 973 Solomons Islan	orge P. K nd Rd. Ed	Kalas Fune Igewater, N	ral Home Md. 21037
No.	Physician /Medical		23. Part1. Enter the disease, or complications that caused the death. shock, or that failure. List only one cause on each line. It mediates a cause (Final disease or condition resulting in death)	L	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death  7 MGNKL
760,	attending physician and mattending physician and more as the burial-fransit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Lifer Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	nce of):				-
O. Box 687	the death certificat the attending phy ched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dead 9 □ Unknown	eath 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
rds, P.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	ğ	Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause given in Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to	o the cause of death?
of Vital Records,	: The law re icate has be ; page 2 sho	Completed				24a. Was an autopsy perform	y prior to	utopsy findings available completion of cause of
f Vita	Physician: this certificate ral director, page 1	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 En	3/Outpatie	Other	h (Check only one	nce 6 ☐ Other (Spe	ecify)
Division o	Attending in death. ector: After by the funer	Certification: To	27. Manner of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hom building, etc. (Specify)	Bb. Time o Injury e, farm, str	Work? M 1 □ Yes 2 □ No	28d. Describe hor 28f. Location (Str. City or Town	reet and Number or R	ural Route Number,
Ω	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Cer	29a. Certifier (Check only one)  Medical Examiner: On the basis of examinatio and manner stated.	edge, deat n and/or ir	h occurred at the time, date and place exestigation, in my opinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier  Allowells UO		29c. License number	29	9d. Date signed (Mont	h, Day, Year) 209
_	Jan.		30. Name and address of person who completed cause of death (Item 2 STVAVT E. SELONICK, M.C.	9	OO Bestgase 1	2d. A	1/13/20 unapolis,	Mid.
	Sta Registi		31. Date filed (Mgn), Ray Year) 2009 3. Registrar's Signature B.	pa	sled			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registra AMEND#15, perFH, 1/20/09, DPS, McCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 13, 2009 **Physician** Alice Jane Cook 5:00 a M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Asbury Home Solomons Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Min 1 ☐ M 2 🛣 F 14, 1921 South Carolina 87 Aug. Director 579-22-3887 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the It silen Experience must be notified at 28a-f shov 1 ☐ Yes 2 X No Maryland Calvert Solomons Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 20688 11750 Asbury Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Itee 1 ☐ Yes 2 😿 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 👿 No Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 2 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2 years Own Home <u> Homemaker</u> None-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Walker Laurel Mae Graves ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15008 Pine Top Lane, Burtonsville, MD 20866 George A. Cook/Son other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Jan. 29 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. Arlington Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Failure To Thrive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 12 years Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🕱 No 4 ☐ Pregnant at time of death 5 Other (specify) s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy perform 1 ☐Yes 2000No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗋 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After tx xNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, ithin 24 hours after death.

the Funeral Director: Aft
properely filled in by the fur within 24 5 0

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Joseph J. Barth,

JAN 16

31. Date filed (Month, Day, Year)

110 Hospital Road, #310, Prince Frederick, MD 20678 III, MD 32 Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

[X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D52242

29d. Date signed (Month, Day, Year)

January 13, 2009

		For State Registrar		State	of Maryl	and / Dep	artmer e <i>rtifica</i> :				1ental Hy	_	e .20	9	02	832
Physicia /Medic		1. Decedent's Name (F		,	I		-	_			2. Date of De Januar	eath			3. Time of 5:30	of Death A M
Examin		4a. Facility Name (If no 90 River	t institution, giv Drive	e street and n	umber)		, ,	Town, or	Location o	of Death		4	County of Anne		ndel	
Funeral Director		5. Social Security Numb 236 48 350	7	Sex 1∭XM 2□ F	7. Age (In 77	yrs. last birthda Yrs.	/) If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bi	rth 193	1	9. Birthp West	olace (State otry Virg	or Foreigr inia
Maryland a-f show	ctor	Usual Residence of De 10a. State 10 MD	b. County Anne A	runde1	10c	. City, Town or								1	0d. Inside 0	City Limits
th with the 23a or 28 ast be not	Funeral Director	10e. Street and Numbe 90 River I					10f. Zi <sub>l</sub>					10g. C	itizen of W	hat Coun	ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine Trust be notified at once.	δ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed F	2 <b>∏X</b> No iive	in U.S. 13	. Was Dece If Yes, spe 1 ☐ Yes	X	ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-		c, White,		
within 72 houene.	Completed		. Decedent's E only highest gr	ade completed	) (1-4or 5+)	(Gin	edent's Usu re kind of wo DO NOT u	ork done o se retire o	during mos d)			Ann		ındel	dustry L Coun	
uld be filed v Mental Hygie rked other i	To Be Co	17. Father's Name (Firs Cornelius				auper	inten	dent	18. Mothe	er's Name	IS (First, Middle Iliff				cacion	1
and 2 shoue saith and N n 27 is ma		19a. Informant's Name Mary Louis				90 1	River	Driv	e/Ann	napo1	al Route Numb is MD	ber, City 2140	or Town, s	State, Zip	Code)	
. Pages 1 tment of He tant: if Iten lury or oth		20a. Method of Disposi 1 ☐ Burial 2 💁 4 ☐ Donation 5 ☐	remation 3 [		State N	ob. Place of Dis cemetery, co Metropo	position (Na ematory or d Litan	me of other plac Crem	atory	, 1/28	3/09		exanc			
permit Depart Import any In		11000	mare	W			Annap	olis	MD a	ind F	remati alls C	hurc		ces		
Physician /Medical Examiner		23a. Part 1. Enter the c shock, or heart fe Immediate Cause (Fin disease or condition resulting in death)	al <b>(</b>	a	me	tasta $\frac{1}{2}$						arrest,			Approxima Interval Be Onset and	etween
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditif any, leading to immer cause. Enter Underlyir Cause (Disease or injutat initiated events resulting in death) Last	diate or or or or or or or or or or or or or	c		nsequence of):										
Attending Physician: The law requires that the death certific refeath.  Aften this certificate has been signed by the attending play the funeral director, page 2 should be detached for use as to the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mod 1 □ Yes 2 □ Nod 9 □ Unknown	nths?	23c. If yes, o 1  Live 4  Pre 9  Unl	birth 2 1 i gnant at time	Fetal death	Ectopic		у				23d. Date Mor	e of delive	ery Day	Year
w requires that been signed be should be deta	ρ	Part II. Other significat	nt conditions	contributing to	death but not	t resulting in the	underlying	cause give	en in Part I			tobacco			ne cause of	
The law recate has bee	Completed										24a. Was auto perfo 1 □ Yes	psy ormed?	d	Vere autorior to coreath?	psy findings mpletion of 2 \Begin{array}{c} No	available cause of
ysician: Thinis certificate director, pag	Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐ No		Hospital:				OA Oth	or:		(Check only					
anding Physath.	ation: To	27. Manner of Death  1 Natural  2 Accident	5 ☐ Pending investigation	28a. Dat (Mo	Inpatient e of Injury nth, Day, Yea	2 ER/Outpat  28b. Time Injury	of .	28c. Injur Work	y at		me 5 Res 28d. Describe			(-)	y)	
	Certification:	4 Homicide	Could not to	buil	ding, etc. (Sp						28f. Location City or To	wn, Sta	te)			nber,
the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical	(Check only 2_ one)	_ Medical Exa	miner: On the	ne best of my basis of examener stated.	knowledge, de mination and/or	investigation	n, in my c	pinion, dea	nd place, ath occur	and due to the red at the time	, date a	nd place, a	ind due to	the cause	(s)
viti O	2	29b. Signature and title	HM.	Gree		LUD			e number	63.	73	29d. D	ate signed			
		30. Name and address	of person who	completed ca	use of death	(Item 23a) (Typ	e, Print)	D	uncp	olis	, us	l.	21	401		
Sta Registra		31. Date filed (Morith, 7	Day, Year) 2 2009	Sins.	Registrar's S	ignature	Nes!									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00597 State of Maryland / Department of Health and Mental Hygiene Harold Hilton Chaney Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 20, 2009 1922 hrs Medical Examiner Harold Hilton Chaney c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Months Days Hours Country) Germany Director 09/10/1955 579-76-8622 53 Yrs 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No Oxon Hill 23a or 28a-f show notified at once  $\mathbf{FG}$ MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 USA 1421 Southern Avenue apt#20 14. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Funeral White, etc Armed Forces? 1 X Never Married 2 Married 1 X Yes No Black Specify: Yes 2 X No specify: imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after a near of Health and Mental Hygiene. If Yes, Give Year Widowed Divorced If item 27 is marked other than "natural", ter traumatic event, the Medical Examiner 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) Self employee HVAC Technician MS 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Baumpardt Harold Britt Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 5934 St. Moritz Drive; Temple Hills, Maryland 20748 Jurgen Chaney - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 02/02/2009 Cheltenham, Maryland Maryland Veteran Cemetery Important: injury or otl Donation 5 Other Specify 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service TUO 4594 Beech Road; Temple Hills, Maryland 20748 aplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or Between Onset and **Physician** are. List only one cause Death Medical Cocaine intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): AMENDED 23a,27,28a-f, perME, g889 3/16/09 TT X UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. No 3 Probably 4 ✔ Unknown Yes 2 ģ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? has 1 🗸 Yes Yes 2 certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be examiner? Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a, Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2X No unk 1 Natural Pending Fd 1/20/09 Fd 6:36 pm Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State 5023 Bass Pl. SE Washington, DC 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide (Specify) Found in a parking lot 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 To the I

Medical

State Registrar 29b. Signature and title of certifier

Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Month, I

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

JRy

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

**OCME** 

29d. Date signed (Month, Day, Year)

January 21, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:17 2009 AM Shirley Rae Dillon Canter Jan. 16, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Mechanicsville 27213 Danville Street 8. Date of Birth (Month, Day, May 5, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours Months Days Washington, DC 1 □ M 2 🖾 F 79 1929 579-36-7812 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c City Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandred must be rudfiled at any injury or other traumatic event, the Medical Evandred must be rudfiled at once. 1 ☐ Yes 21 No Mechanicsville Director Maryland St. Mary's 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 27213 Danville Street 20659 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify: White 2 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Ann Lewis Raymond James Dillon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5006 Indian Lane, College Park, MD 20740 Judith Campbell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2009 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Years **Physician** disease or condition resulting in death) Respiratory Insufficiency /Medical Due to (or as a consequence of): Due to Emphysema Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 🔲 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/16/2009 D000506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Berube, 28170 Old Village Road, Mechanicsville, MD 20659

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARYANN DULIK Jan. 15, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hewbrew Home of Washington Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 220-14-3178 Director May 8,1923 PA Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 Yes 2 □ No Director VA Loudon 28a-f Great Falls 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 10507 Cambridge 22066 Funeral U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 \( \subseteq Yes \) 2 \( \supseteq No \) or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2√2 No Specify. \$ Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Irs. Magnes. 9008. College (1-4or 5+) Elementary/Secondary (0-12) Domestic Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Dulik- Husband 10507 Cambridge Ct Great Falls, VA 22066 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/19/09 Mount McRina New Salem, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home, PA 246 N. Washington St Rockville, MD20850 Part 1. Enter the diseas / r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failur: List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** umoni disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) P.0. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate performe 2 No of Vital 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 2 Accident 5 Pending To the Hospital or Attendity within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 □Yes 2 □ No Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D35/68 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

Year)

Linda A

Benson,

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2009 )unr lander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washingtor toh Washington aciers 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 X M 2 □ F Months Days Hours Min Marylano Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 610 Funeral hington 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: White <u>چ</u> Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Plant Elementary/Secondary (0-12) College (1-4or 5+) Mineral Processing Financia onsultan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OHolec ပ trancis Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie le CotsWold lerrace Unit 3A Dunn-Gireensboro, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State mithsburg Cremitary 1-22-2009 Smithsburg, M.D 4 Donation 5 Dother (Specify) 22. Name and Address of Ficility Dug as A. Fiery Funeral Home 21. Signature of Funeral Service Lice 1331 Eastern Blid North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 the oscherot. a (Drong 1) secred disease or condition resulting in death) Due to (or as a consequence of) ypertinsiva Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

has been signed by the attending physician a 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical 9 ρ page 2 should Completed certificate Hospital or Attending Physician; director, Be မှ After this funeral c Certification: within 24 hours after death. To the Funeral Director; A filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check o

mo

29c. License number 00056965

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add

32. R

251 Ant. et mo

31. Date filed (Month, Day, Year)

one) 29b. Signatu

distrar's Signature

State Registrar

**Funeral** 

Director

28a-f show

Department of Health and Mental Hygiene. Important: If Item 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Invidical Examinating the Invidited 21.

filed within 7 I Hygiene.

s 1 and 2 should be filed wi if Health and Mental Hygier Item 27 Is marked other th

Pages 1

**Physician** 

/Medical

Examiner

burial-transit

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02837 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician Month Olive C. Dinterman January 18, 2009 3:15 AM /Medical 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Glade Valley Nursing Home Walkersville Frederick 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral** Days 1 ☐ M 2 🛱 F Months 95 Yrs 215-10-2504 May 12, 1913 Director Usual Residence of Decedent Peges 1 end 2 should be filled within 72 hours efter deeth with the Maryland nent of Heelth and Mentel Hygiene.

ant: If Item 27 is marked other than "naturel", or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 XNo Maryland Frederick Woodsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11166 Coppermine Road United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: Specify: White ð 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Krantz Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Rossi / Granddaughter 11166 Coppermine Road, Woodsboro, MD 21798 20a. Method of Disposition 20b. Place of Disposition (Name of Jan.21, 20c. Location - City or Town, State cemeter, crematory or other place)
Resthaven
Memorial Gardens Depertment of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) a Alzheimer's Dementia **Examiner** Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours effer deeth.

To the Funeral Director: After this certificete hes been signed by the ettending physician end Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2XX No Renal Insufficiency Medical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 488 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XXNo 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. (Check only 29b. Signatureyend title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5060 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kathryn Troupe 1475 Taney Ave., Frederick, MD 21702

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 Jean Rosina Dacre 6,36 P January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Months Hours 1 □ M 2 🖾 F Director 433-98-6543 22,1931 England Sept. Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7209 E. Sundown Court 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 TNo Specify. White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk h and Mental Hygier 7 is marked other th Department Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 01ney ပ Unknown Unknown Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Kenneth J. Dacre / Son 7209 E. Sundown Court Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 17, 2009 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 OPossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Kaile Physician HOULS disease or condition resulting in death) /Medical Examiner YEARS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒No 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) ed by the detached t 9 ☐ Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 2 🛛 No 1 ☐ Yes 2 🖾 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Director filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s). (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20062223 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PRENERICE MD -21702 ,196 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 Y93 Month 0815 м **Physician** Frances Beth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Allegany WMHS-Braddock Campus Cumberland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F 72 Jan. 8,1937 Webster Co., WV 235-56-7706 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Wedical Exactive must be notified at once. 1 Yes 2 □ No Director WV Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 26726 695 Armstrong Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: 2 White 3 👿 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress/Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Opal E. Cogar Clarence H. Mustoe ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy E. Modlin/Daughter Bunker Hill, WV 25413 95 Currituck Co<u>urt</u> 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 4 Donation 5 Dother (Specify) 2009 Keyser, WV Potomac Memorial Gardens 22. Name and Address of Facility 21. Signature of Funeral Service Li lenses Smith Funeral Home 85 S. Main Street Keyser, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one capse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3441 200 vessive **Physician** /Medical Due to wr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for selections are not of suc-Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗓 No 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 D No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 2 □No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ALT Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jan 25, 2009 10033280

State Registrar Avenue

Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aupta

31. Date filed (Month, Day,

625

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 02840 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da Year **Physician** anuary 30 2009 8:25 PM noades /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington 9. Birthplace (State or Foreign Country) inte 01 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Min. 1 XM 2□ F Months Days Hours 8 -18-8634 Penns Director IVahia Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It whe lies Exacting to prove that the provided at 1 Yes 2 □ No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 2174-2 Ylace Funeral chiamin 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates: +3 - +4 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 2 Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Herospace Industr Mechanica ngincer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Enterline ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Wood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland 1-24-2009 4 ☐ Donation 5 ☐ Other (Specify) emeter A. Flery Funeral Home 22. Name and Address of cility Douglas 21. Signature of Funeral Service Licer 1331 Eastern Blvd. North Hagerstown, MD 2174-2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician WEBY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the burlar-lytansit ARUMADO Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ፩ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed WHIP IROTORY death? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Thedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) 00H9+ egistrar's Signature 31. Date filed (Month, Day, Year) 32. State JAN 2 2 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 11, 2009 7:21 P N William Η. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Ft. Washington Hospital Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** Days ¥X M 2□F 86 224-18-9646 Director July 15, Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene. "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Prince George's Ft. Washington 1 ☐ Yes 24XXXIO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Potomac Valley Drive 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1949— If Yes, Give Year or Dates: 1979 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2/CXNo Black δ Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Colonel U.S. Army Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eulasties Eaton Ida Copeland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Potomac Valley Drive Ft. Washington, Maryland Juanita V. Eaton / Wife 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/25/2009 Arlington Nat. Cemetery Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

21

Arvind Narasimhan

Ft. Washington Hospital Livingston Rd., Ft. Washington, MD 31. Date filed (Month, Day, Year) 32. Registrar's signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

NOUSLOS

29d. Date signed (Month, Day, Year)

January 13, 2009

20744

				epartment of Health and N Certificate of Death		ne 2009	02842
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Bertha Wilhelmina Frase		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of Death	0800 M
			William Hill Manor  5. Social Security Number 6. Sex 7. Age (In yrs. last birt.	Easton  Hoday) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Ta1bo	ace (State or Foreign
	Funeral Director		220-01-5071 1 M 2 X F 94	/rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 2, 1	914 Mary	land
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	or Location		10	d. Inside City Limits
	ne Mary 8a-fsh diffical	ector	MD Caroline	Preston	10-	. Citizen of What Count	1 □Yes 2 □XNo
	3a or 2	al Dire	10e. Street and Number 3656 Choptank Avenue	10f. Zip Code 21655		United St	
136	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, it medical Eventinal must be multinal at	by Funeral Director	11. Marital Status  1X_Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☐ Yes 2 ☐ X No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Wh	
2-0036	72 hou 'natura dien E			Decedent's Usual Occupation (Give kind of work done during most of work	ing   161	b. Kind of Business/Ind	ustry
1217	filed within Hygiene. Ither than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	`life. DO NOT use retired) Caregiver	Fa	amily Car	etaker
yland ,		Be	17. Father's Name (First, Middle, Last) Gustav C. Frase		<sub>e (First, Middle, Mai</sub> a Hintz	iden Surname)	
Ε.	s 1 and 2 should f Health and Mei tem 27 is marke other traumatic	ဥ	19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or Rul		City or Town, State, Zip	Code)
e, ⊠a	l and 2 Health a sm 27 is			281 Newton Road,		MD 2165	
E E	% O -		11 M Burial 21 ICremation 31 I Bernoval from State 1 =	y, crematory or other place)	· .	reston, M	<i>'</i>
Baltimore,	permit. Page Department of Important; If any Injury or once.		21. Signature of Funeral Service Licensee  M. W. T. Gubw	22. Name and Address of Facility Fra 216 N. Main St., F	amptom Fur ederalsbu	neral Home, urg, MD 2163	P.A. 32
			23a. Part 1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.			t,	Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	Styperatory C	Culest	/-	seemes
	Examiner	<u>.</u>	Sequentially list conditions, b.  Due to (or as a ponsequence of the conditions)	50.			seconds
	cuted id ansit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	cleroti Heart	Disease	1	et your
8760,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of	rf):			,
9	rtificate ng phys as the	Medical	IF FEMALE:				
O. Box	the death certifi	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year
rds, P	w requires that the dispension is been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the	
al Records,	The lar ate has	Completed	Gashi esophageal Refley	rejn- Deseare	24a. Was an autopsy performe 1 □ Yes 2 P	prior to con death?	osy findings available inpletion of cause of
. Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1☐ Yes 2☐ No  Hospital: 1☐ Inpatient 2☐ ER/Ou		th (Check only one) ome 5 Residence	ce 6 ☐ Other (Specify	·)
- -	ine ine	on:T	27. Manner of Death 1 ☑ Natural 5 ☑ Pending (Month, Day, Year) 28b. 1	Fime of 28c. Injury at hijury Work?	28d. Describe how		,
Division of	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	12.100	28f. Location (Stree City or Town, S	et and Number or Rural State)	l Route Number,
_	e Hospita 124 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu	, and due to the cau rred at the time, date	use(s) and manner as si e and place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d	d. Date signed (Month, I	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		1/19/07	
			William H. Wood, MD 501 E		Easton, /	MD 2160	l
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Janes 1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 16, 2009 2245 Linda Stevens Fellows /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number Funeral Months Days 1 ☐ M 2 🕏 F Hours Director 220-52-7799 59 June 19, 1949 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes X☐ No Director Trappe Maryland Talbot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21673 4166 Claylands Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No <sup>Specify:</sup> Caucasian þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) the High School Education Guidance Counselor/Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Morris Blackistone William Stevens Orme 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4166 Claylands Road, Trappe, Maryland Jeffrey E. Fellows Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit, Pages 1
Department of P
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Capitol Crematory 1/18/2009 Dover, Delaware 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Ventricular Fibrillation Due to (or as a consequence of): Seconds /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Acute Myocardial Injury Seconds Examiner certificate be executed Arteriosclerotic Cardiovascular Disease and Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 █ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2□ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 A ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Records, Division or Vital To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A

Saltimore, Maryland 21215-0036

Box 68760.

P.0.

State Registrar

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Robert B. Sanchez, M.D.

JAN 21 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapmer stated. 29c. License number

D25750

508 Idlewild Avenue, Easton, Maryland 21601

29d. Date signed (Month, Day, Year)

January 17, 2009

Amondod #20h	20	for State Registrar 1/21/09,	State o	f Maryland /	Depa	artment of F	Health and M	Mental Hy	giene 0	)9	02844
Amended #20b,	20	1. Decedent's Name (First, Middle		60.	061	incate or	Deatit	2. Date of De	Reg. No.		3. Time of Death
Physic /Medi		Julius John	Eard					Month C I	Day 16 &	Year 2009	9:35 a M
Exami		4a. Facility Name (If not institution		mber)		4b. City, Town, o	or Location of Death	1	4c. County	of Death	
		600 CANNON ST				Chester		T	KEN		
Funeral		5. Social Security Number	6. Sex 1 → M 2 ☐ F	7. Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D.	ay, Year)	9. Birth Coι	place (State or Foreign untry)
Director		218.30.1266 Usual Residence of Decedent		7.3				07 18	3 1935		70
rylanc thow		10a. State 10b. County		10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
9e Ma Se-1 s	Director	MO KENT		Chesti	erto						1 ☐ Yes 2 ☐ No
with the a or 2		10e. Street and Number	0			10f. Zip Code			10g. Citizen of \		untry?
ns 23	Funerai	600 CANDON ST.	12. Was Dece	edent Ever in U.S.	13. V	21620 Vas Decedent of F	Hispanic Origin? (Sp	pecify Yes or N	US A		ican Indian,
5 after d or ften	臣	1 ♣ Never Married 2 Marr	ied 1 ☐ Yes	rces? 2. <b>⊒+</b> €6	If	Yes, specify Cub	an, Mexican, Puerto	o Rican, etc.)	Blac	ck, White	, etc.
ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ates:		Yes 2 No	Specify:		Specify	BIA	ek
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withii iene.	dwo	Elementary/Secondary (0-12)	College (1				STRUCTION		LINADA	d Co	ASTELLETION CO.
e filed other vent,	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's Nam				
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23a or 28e-1 show aumatic event, the Medical Evaniner must be notified at	10 E	Julius John F	ford				AIBERTA	POAN	55		
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-1 shouther traumatic event, the Medical Evandrer must be notified at		19a. Informant's Name/Relations		130			and Number or Ru				ip Code)
Te, M 1 and 2 Health tem 27		CONSTANCE Brown  20a. Method of Disposition	on-Cousin	20h Place	of Dispos	sition (Name of	Dr. Cheste	Date	20c. Location		o 2 &
Pages nent of the first or of or or or or or or or or or or or or or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State Capit	ery, crem O I (	atory or other pla Crematory	01/	22/09	Dover,	200	
Baltimore, Mispermit. Pages 1 and 2 Department of Health 2 Important: If Item 27 is any injury or other transones.		21. Sign rure of Funeral Service			22	. Name and Addre	1121 01 "	_1			1 Service
E S S S S S S S S S S S S S S S S S S S		puce O.	Walle	1/200020		21 W. ST. A			121401		
		23a Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	aused the death. Do	not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	Heute	My	o can de	al Inf	oretw	ń.		Onset and Death
/Medical Examiner		resuming in death)	Due to	(or as a consequence	of):			)			
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(U) as a consequente	o Ui).					-	
cuted	Examiner	Cause (Disease or injury that initiated events	S								
8760, rate be executed hysician and the burial-transit		resulting in death) Last	Due to	(or as a consequence	of):						
X 68760, certificate be executed dding physician and use as the burial-transil	hysician/Medical		d								
Box 68 Box entitica sattending pt	/Me	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy					23d. Da	te of deliv	verv
Bo death death	Iciar	in the past 12 months?	4 Pregr	oirth 2 🗌 Fetal deat nant at time of death		Ectopic pregnanc Other (s <i>pecify</i> ) _	у		1	nth	Day Year
P.O. that the de by the detached	Phys	9 Unknown	9□ Unkn								
	by	Part II. Other significant condition	ons contributing to d	eath but not resulting	in the un	nderlying cause gr	ven in Part I.		tobacco use cont Yes 2 □ No	ribute to	the cause of death?
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Da at a bag	e Co	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2 🗆 No	Yes	2 No
of Vita Of Vita Physician:	0	examiner? 1 Yes 2 No	Moonital:	Inpatient 2 ER/C	utpatien	t 3 DOA	ner: 4 Nursing H			er (Speci	ify)
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isio wtendi death.	catio	2 Accident investig	gation				Yes 2□No	004 )	/O+ / + 1		
Division or Attending after death. Director: After	Certification:	4 Homicide determ	nined 28e. Place build	of Injury - At home, ting, etc. (Specify)	tarm, stre	eet, factory, office		City or To	wn, State)	er or Hur	ral Route Number,
E Hospitel 74 hours a 6 Funnerel teletely tilled				best of my knowledge							
Division  To the Hospitel or Attending within 24 hours atter death.  To the Funerel Director: Alter completely tilled in by the fune	ledical	one)	and man	asis of examination a ner stated.	ind/or inv			rred at the time,			
Tol	Σ	29b. Signature and title of pertifie	0 9//			29c. Licens		,	29d. Date signe	(Month)	. Day, Year)
1		30. Name and address of person	ho completed caus	se of death (Item 23a	) (Type		060301		200	. O 9	
m 5		31. Date filed (Month, Day, Year)	EJ WENT	tegistrade Signature	1 5/	lesn Bo	502 5	Cap	जडाखा। इंडाखा	our	1, m
Regist	ate trar	JAN	2 0 2009	Beaus	A.	parke	7				

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	Dhoolat		Decedent's Name (First, Middle, Last)		2. Date of Death  Month Day Year	3. Time of Death
	Physicia /Medic		Joseph William Gehr, Sr.		January 22 200	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	ath
			13626 Big Pool Rd.	Clear Spring	Washi	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi.	Months Days Hours Min.	(Month, Day, Year)	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		July 19,1917   M	aryland
	land w		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary -f sh	ţ	Maryland Washington	Cloom Coming		1 ☐ Yes 2 🕅 No
	ith the Marylar or 28a-f show	rec	10e. Street and Number	Clear Spring 10f. Zip Code	10g. Citizen of What (	Country?
	h with	9	13626 Big Pool Rd.	21722	US	Α
	deat	ner		Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- 14. Race - An	nerican Indian,
9	or Ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖔 🗓 No	1 ☐ Yes 2X No Specify:	ican, etc.) Black, Wh	iite, etc.
215-0036	within 72 hours after death with the Maryland ene. than "netural", or lieme 23a or 28a-f show the Madical Examithat court be matified at	d b	3 X Widowed 4 ☐ Divorced Year or Dates:	1 103 22 110 Specify.	Зреспу.	White
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d 21	Hygie ther ant,		8 17. Father's Name (First, Middle, Last)	Driver 18. Mother's Name	(First, Middle, Maiden Sumame)	ortation
Maryland	d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than ". freumatic event, the Mad	o Be	William Russell Gehr	Laura	Elizabeth Shup	
<u></u>	shout od Me mark matt	ို		ailing Address (Street and Number or Rural		
M	ad 2::		Joseph Gehr, Jr Son 136	643 Big Pool Rd. Cle	er Spring Maryl	and 21722
<u>6</u>	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene If item 27 is marked other than "netural", or iteme 23a or 28a-f show or other treumatic event, it is Madical Examinat, must be notified at		20a. Method of Disposition 20b. Place of Di	sposition (Name of Dacematory or other place)		
Ë	Page lent o nt: If ry or		1 LABuriai 2 Ucremation 3 Hemoval from State	ding Cem. Jan.26	2009 Hageristo	wn, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.			Styperned fourset ad the Home		mily Mary rand
m	Depar Depar Impor any ir			125 S. Conococheague		t, MD 21795
			23a. Part. Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	and and le	21	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	mony occius	2100	2004021
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	sit ad	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury	200	,	7 3
	and i-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	alE	330 to (or 40 40 50 100 400 100 51).			
387		dlcal	d			
×	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
Вох	d for I	Iclai	in the past 12 months?  1 \( \text{Ves} \) z \( \text{No} \)  1 \( \text{Ves} \) z \( \text{No} \)  1 \( \text{Ves} \) z \( \text{No} \)	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month	Day Year
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rd	w require been sig should b				1 ☐ Yes 25 No 3 ☐	Probably 4 Unknown
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E.	The ate he page	mo;			performed? death?	
Vital	sian: artifica ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death		
of V	Physician: The lav this certificate hes ral director, page 2	To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA Other: 4 Nursing Hom	e 5 Residence 6 □Other (Sp	necify)
	dter uner	on:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Tim (Month, Day Year)	y Work?	d. Describe how injury occurred	
sio	Attending r death. sctor: Alte	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
Division	I or Attendi after death. Director: A in by the fu	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	3f. Location (Street and Number or a City or Town, State)	Rural Houte Number,
	pital ours a erel filled	Ö	29a. Certifier Certifying Physicien: To the best of my knowledge, di	Path occurred at the time, date and place, as	and due to the cause/s) and messes	ne stated
	24 hos Even etely	Medical	(Check only one)    Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occurre	d at the time, date and place, and di	ue to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo.	nth, Day, Year)
			Marine V. Vis	120011266	San 2	3 09
_			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		1
0	4-4		HN WALKSMD 130	Vertion Av Ha	presoun Int	
н	Sta		31. Date filed (Month, Day, Year)  JAN 2 3 2009  32. Registrar's Signature	1		
	Registr			Mar Val		

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDWARD 22:06M 2009 NAC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE 8. Date of Birth (Month, Day, Year) BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTRA If Under If Under 24 H 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min Months Days Hours 1⊠M 2□ F WASHINGTON, DC 1966 219-96-9751 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b County and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show a marked other than "natural", or Items 23a or 28a-f show a marked other than "natural to recitly of at raumatic event, the Medical Eventing 1 Yes 2 □ No Director PRINCE GEROGE'S LANHAM MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 USA 9337 WASHINGTON BLVD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No RESERVE If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ir. M. SYSTEM TECHNICIAN PRIVATE 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RECTNA GRAY EDWARD S. GRAYSON JR ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4203 KINMONT ROAD LANHAM, MARYLAND 20706 EDWARD S. GRAYSON JR./FATHER 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Goodhope Norman 1/16/2009 CULPEPPER, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) Church Cemeters J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 20785 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner INTRACERES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∏Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 1010. 225. GREENE ST, BARTI State Registrar

da Hicks		Registrar	epartment of Certificate of		Reg	No. 20	09 0284
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Linda Lou Hicks			2. Date of Death  Month  D  January 15,	Day Year 2009	3. Time of Death 1800 hrs
		4a. Facility Name (if not institution, give street and number) 1917 Elmwood Park Drive	41	b. City, Town, or Location of Death  Capitol Heights		4c. County of Deat Prince Georg	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In 231–82–9196 1 M 2XF	yrs. last birthday) 54 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Min	<b>-</b>	MM/DD/YYYY) 9. Bi Forei	
nd show any:	J.		City, Town or Location				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number 1917 Elmwood Park Drive		10f. Zip Code 20743	10g.	Citizen of What Cou	intry?
3, MD 21215-0036 Had 2 should be filed within 72 hours after death with the Maryland leafth and Montal Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	y Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X 3 Widowed 4 X Divorced Fyes, Give Year	If Ye	s Decedent of Hispanic Origin? (Ss., specify Cuban, Mexican, Puerto Yes 2 X No specify:		White, etc.	nite
5-0036 led within 72 hours at Hygiene other than "natural the Medical Examin	Completed by	15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)	ed) 16a. Decedent	's Usual Occupation (Give kind of ist of working life. DO NOT use re		6b. Kind of Business.	•
21215-0036 wild be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) John Gordan Williams		18.Mother's Nam Doris M.		iden Sumame)	
Baltimore, MD 2121 permit. Pages I and 2 should be f Department of Health and Mental Important: If item 27 is market injury or other tranmatic event.	T	1 Burial 2 X Cremation 3 Removal from State	7910 F 20b. Place of Disposit crematory or othe	Address (Street and Number or Clamingo Drive Atton (Name of cemetery, er place)	lexandria Date	NA 2230 20c. Location - City o	76 r Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: 21. Schature of Fungral Service Licensee		Crematory 01		denton, Modern P.O. B	
Physician /Medical caminer	Examiner	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Machine Mach	nce of):	ene intoxicatio		, orient, or reality	Between Onset and Death
68760, ertificate be ex ding physician e as the burial	ian/Medical	X UNPENDED AMENDED 23a, 2  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of the line birth to be past 12 months?	f pregnancy	perME, g888 2/1		23d. Date of deliver	ry Day Year
J. Box at the death c by the atten ached for us	Physician/IV	1 Yes 2 No 9 V Unknown 9 Unknown	3 Otn	ner (Specify)  nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ords, P.O. w requires that the is been signed by should be detach	Completed by				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
of Vital Records, g Physician: The law require. The this certificate has been s' neral director, page 2 should b	Be Com	25. Was case referred to medical		26.Place of Death (Check	performe 1 Yes 2 conly one)		es 2 No
	욘	examiner? Hospital: 1 Inpatient  27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 1 Accident Investigation Fd 1/15/09	28b. Time of In	njury 28c. Injury at Work?	ng Home 5 Re 28d. Describe how unk	esidence 6 Other	er: Scene
ViS or At fter d Direct in by	Certification:	Suicide 6X Could not be determined (Specify) hou	- At home, farm, street	t, factory, office building, etc.	or Town, Stat Capitol	Heights,	ural Route Number, City Wood Pike Dr
Div To the Hospital or within 24 hours afte To the Emeral Dir completely filled in	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated.		on, in my opinion, death occurred	at the time, date an	d place, and due to t	he cause(s)
	N	29b. Signature and title of certifier		29c. License number O. C.M.E.		29d. Date signed (Mo	_
(F)02		30. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical	` '	Penn Street, Baltimore,	MD 21201		
S	tate	31. Date filed (Month Day, Year) 32. Registrar's S	ignature.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JAMES HOPKINS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Wicomico MIDIEM SALISHIN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) EC 25, 1953 7. Age (In vrs. last birthday) **Funeral** LEWES. Months Days 1 € M 2 □ F DELAWARE 55 DEC 221-40-3389 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Medical Evantral must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director MARYLAND WICOMICO SALISBURY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 U.S.A. 229 CHESTNUT WAY Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: BLACK Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LONG DISTANCE TRUCK DRIVER TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES WISE MINNIE HOPKINS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 229 CHESTNUT WAY, SALISBURY, MD 21804 RAMONA HOPKINS / WIFE Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ST JOHN CHURCH CEMETERY 1/24/09 MILLSBORO, DELAWARE 4 Donation 5 DOther (Specify) 22. Name and Address of Facility
WATSON FUNERAL HOME
Mooles 211 WASHINGTON ST, MILLSBORO, DE 19966 21. Signature Funeral Service Licensee low Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOMTORATHY **Physician** MONTH S /Medical Due to (or as a consequence of): Examiner AD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 24 hours after te Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certific

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

DHMH 17 Rev 1/2001

MD, PhD

29c. License number

100e CARROLL St. SALISBURY Md 21801

29d. Date signed (Month, Day, Year)

			State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. N2 0 0 9 0 2 8	149
	Physici /Media	al	Volgania L. Hace January 21, 20091.	5 PM
	Examir Funeral Director	ier	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4d. County o	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: if item 27 is marked other than "naturel", or items 23s or 28e-f show any injury or other treumetic event, the Machael Examination internual be notified at once.	To Be Completed by Funeral Director	3 Widowed 4 Divorced Page Give 1 Specify: Specify: White  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12  17. Father's Name (First, Middle, Last)  Specify: White	21078
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Q	To the Hospitel or within 24 hours after To the Funerel Director completely filled in It	edical Cer		·····
	To the within To the comple	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	
• •	Sta Registi		31. Date filed (Month, Day Year)  32. Redistrars Signature  32. Redistrars Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, 2009 JAN. 1647 MILDRED WHITEHEAD HALL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital MONTGOMERY Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days 1 M 25 Sept. 22, 1925 83 N.Carolina 578-40-5464 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13723 Wagon Way 20906 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐Yes 2 ☑ No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary H.H.S. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Boone James W. Whitehead ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13723 Wagon Way, Silver Spring, MD 20906 Wiley A. Hall (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem 1/24/09 Silver Spring, MD SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he int failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to ( as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

sician and burial-transit cate has been signed by the attending physician page 2 should be detached for use as the burial certificate has spital or Attending Physician: Theores after death.
neral Director; After this certificate y filled in by the funeral director, pa Hospital c 24 hours at To the Hospital within 24 hours a To the Funeral L

**Funeral** 

Director

28a-f show

tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, It is Marite once.

**Physician** /Medical

**Examiner** 

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

29b. Signature and title of certif

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

	1 - State Registrar					partment of <i>ertificate o</i>				Reg. No.	2009	0285
ian cal	1. Decedent's Na GENE	ame (First, Middle ARTHUI		1	HESSEY				2. Date of D Month <b>JAN</b> .	eath 19, <sup>Day</sup>	009 Year	3. Time of Death 12:28 A M
ai er		(If not institution	. 0	number)		4b. City, Town		of Death		4c. C	County of Dea	ath
	5. Social Security 272–30–	/ Number	6. Sex 1 M 2 □ F	7. Age (In y	rs. last birthda Yrs	Months Day	ar If Under	r 24 Hrs. Min.	8. Date of B (Month, I	irth Day, Year)		rthplace (State or Foreign country)  OH
	Usual Residence				City, Town or	Location			J/1J/1	734		10d. Inside City Limits
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Dy I MIICIAI	11. Marital Status		12. Was D Armed 1 Tye	Decedent Ever in I Forces? es 24 No Give or Dates:	U.S. 1	3. Was Decedent of If Yes, specify Co	of Hispanic O uban, Mexica		ecify Yes or N Rican, etc.)	lo- 14	4. Race - Am Black, Whi	erican Indian, te, etc.
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	1 🗆 Burial	2 <b>X</b> Cremation n 5 ⊟Other <i>(S)</i>	3 ☐ Removal fro	om State		sposition (Name of crematory or other p	i				,	LLE, MD
	21. Signature of	Funeral Service I	Licensee,	1 1 6		22. Name and Add	dress of Facil	lity ENBEI	N & NE	WNAM I	FUNERA	
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DHMH 17 Rev 1/2001

**Physician** 

/Medical

Examiner

**Funeral Director** 

**Funeral Director** 

Be Completed by

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**Physician** 

/Medical

attending physician and for use as the burial-trar

State Registrar			f Maryland / Department of Health and N Certificate of Death						Reg. No. 2000				
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, Father's Name	(First, Middle, L	.ast)		•					e (First, Middle, M		name)		
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a. Informant's N	lame/Relationsh	ip (Type. Print)		19b.	Mailing A	ddress (Stre	eet and Numbe	er or Run	al Route Number,	City or To	wn, State, 2	Zip Code)	
	UNTLEY/	HUSBAND							HESTERTOV				
a. Method of Dis	Cremation	3 Removal from	State	ob. Place of cemeter	Disposition, cremato	on (Name of ory or other p	olace)	[	Date 2	0c. Locati	on - City or	Town, Star	e
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Be Completed by Physician/Medical Medical Certification: To

Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the s completely filled in by the funeral director, page 2 should be detached for 3

ms

State Registrar 30. Name and address of MD Neil Stooldard 31. Date filed (Month

29b. Signature and title of certifier

D0050996

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

100 Brown St. Clasta town MD 21620

and manner stated.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	arylanu /	•	tificate of D		i ivieritai my	Reg. N	0000	02853		
	Physicia	an	1. Decedent's Name (First, Middle,		1				2. Date of Do Month	D	ay Year	3. Time of Death		
¥	/Medic Examin	al	BERNARD  4a. Facility Name (If not institution,	HEPBRON give street and number)	<b>/</b>		4b. City, Town, or L	ocation of De	JANUAR		2 2009 c. County of Deat			
				AYVIEW MEI			BALT/M If Under 1 Year	ORE	70 To D + 15		l o Birri	(0)		
Ì	Funeral Director		5. Social Security Number 218–16–8728  Usual Residence of Decedent	5. Sex 7. Age 1 🕅 M 2 ☐ F	e (In yrs. last	Yrs.	Months Days	Hours Mi	rs. 8. Date of Bi (Month, D 3/17/	irth Pay, Yea 1923	7) 9. Birt Co	hplace (State or Foreign untry)  MD		
	yland how		10a. State 10b. County	-	10c. City, To	own or Loca	ation					10d. Inside City Limits		
	e Mar 8a-f sl	Director	MD KENT	ROCK	HALL	T			1 □ Yes 2 □XNo					
	with the	į	10e. Street and Number 5810 JUDEFINE A	J.E.			10f. Zip Code 21661				Citizen of What Co USA	untry?		
(0	be filed within 72 hours after death with the Maryland nal Hygiene. ed other than "natural", or items 23a or 28a-f show event, it a Medical Evanime must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	Ever in U.S.		/as Decedent of His Yes, specify Cuban,		(Specify Yes or Nerto Rican, etc.)		14. Race - Ame Black, White				
Maryland 21215-0036	ural", c	d by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:				Specify:		1.00	ETEROLE IS	IITE		
15-	in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		(Give k	ent's Usual Occupat ind of work done du O NOT use retired)	ion ring most of w	rorking	16b.	Kind of Business/	Industry		
212	d with giene er tha	Com	Elementary/Secondary (0-12)	College (1-4or 5	, I	LABOR	T				BLIC WOR	KS		
and	should be filed withir nd Mental Hygiene. marked other than matic event, the Ma	Be	17. Father's Name (First, Middle, La PERCY HEPBRON				18. Mother's N EDNA D	ame <i>(First, Middle</i>	e, Maide	en Surname)				
ız	2 should n and Mer is marke raumatic	우	19a. Informant's Name/Relationshi	1	19b. Mailing	Address (Street an			ber, City	or Town, State, 2	Zip Code)			
	and 2 sealth a n 27 is		ESTHER HARRISON				CIRCLE PA		ROCK HA	LL,	MD 21661			
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3				ition (Name of atory or other place)	i	Date	20c.	Location - City or	Town, State		
<u>=</u>	artmer artmer ortant: Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li	••	WESL	EY CH.			15/09		CK HALL,			
Ba	permit. Departi Importi any Inji		> Kup St	Helfert	2ن	FE	Name and Address LLOWS, HE O SPEER R	LFENBE: D. CHE	IN & NEWI STERTOWN	NAM , MD	FUNERAL 21620	HOME		
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68760,	tificate be executed g physician and as the burial-transit	edical E	Due to (or as a consequence of):											
			IF FEMALE:				G	ER.						
P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	by Physician/N	23b. Was decedent pregnant in the past 12 months?  1							23d. Date of delivery  Month Day Year				
rds, P.	quires that n signed b ıld be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								oacco use contribute to the cause of death es 2 □ No 3 □ Probably 4 ☑ Unkr			
Division of Vital Records,	The law require te has been si age 2 should b	Completed						<u> </u>	24a. Was - auto perf 1 □ Yes	opsy formed?	prior to death?	topsy findings available completion of cause of		
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of	Physi r this c ral dire	٠ <u>.</u>	1 ✓ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 ER	/Outpatient	3 DOA Other	4 LI Nursing		dome 5 ☐ Residence 6 ☐ Other (Specify)				
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<u>Nis</u>	I or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	of be	ury - At home c. (Specify)	e, farm, stree			28f. Location City or To	(Street a	and Number or Ru ate)	Iral Route Number		
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	To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical E	xaminer: On the basis o and manner sta	f examination	n and/or inve	estigation, in my opi	inion, death o	ccurred at the time	, date a	nd place, and due	to the cause(s)		
	Vith To t	Σ	29b. Signature and title of certifier	1			29c. License				Date signed (Month			
)	10		30. Name and address of person w	ho completed cause of d	eath (Item 22	Ra) (Type P	RES-	000		JAN	JUARY 12	, 2009		
	ns		SAJID SHAH	4940 EAS	TEAN	AVE,	BALTIM	ORE, M	D 212	24				
	Sta Registr		31. Date filed (Month, Day, Year)	4940 EAS 32. Registr	r's Signature	A	ball							
	Hogisti		TH W	4 7 TRIM 7 // L	4000	100								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 9, 2009 02:00 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Caroline Goldsboro 14596 Jarrell Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2√X 202-18-2485 Landenberg, Director 85 3/17/1923 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, "to Modical Expressions must be notified at 1 ☐ Yes 2 XNo Funeral Director Caroline Goldsboro MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumation. U.S.A. 21636 14596 Jarrell Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White Completed by 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chemical Company Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mae Etta Holten John F. Bryan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 19943 4396 Firetower Road, Felton, DE David Hansen/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/13/2009 Oxford, PA Oxford Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad St., Middletown, DE 21. Signature of Funeral Service Licensee any In LLC 19709 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ast only one cause on each line. Immediate Cause (Final hybertension **Physician** u monary ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Scleroderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed nding physician and se as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 🖾 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident

Box 68760. Ö ۵. of Vital Records, funeral director, To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera After Division

Baltimore, Maryland 21215-0036

30

6 ☐ Could not be

determined

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifie

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

219 S. Washington St., Easton, MD 21601 Vaidyanathan, MD, Lakshmi

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		artment of F rtificate of I			giene Reg. No. 2 N	nα	02855		
			1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ith	<u></u>	3. Time of Death		
	Physici /Medic		MAHARI	HAILE	JANUAR	Y 10 200	Year 19	7:20 P M					
The same of	Examin		4a. Facility Name (If not institution, give				Location of Death		4c. County		oponia		
meter of			6711 CENTRAL AV 5. Social Security Number 6. S		et hirthday)	CAPITO.  If Under 1 Year	L HEIGHTS				ORGE S		
	Funeral Director			© M 2□ F 69	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day JULY 1	1939	Cour	ntry)		
	ъ		Usual Residence of Decedent										
	show	<u>_</u>	10a. State 10b. County		Town or Lo					1	10d. Inside City Limits		
	the M	Director	MD PRINCE G	EORGE'S CA	APITOL	HEIGHTS  10f. Zip Code			10g. Citizen of W	/hat Coun	1. Yes 2 No		
	with 3a or	Ö	6711 CENTRAL AVE	NIIF		20743			USA		,		
	death ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-			an Indian,		
21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show up or other traumatic event, I'm Prodical Evanting roughly incitified at up or other traumatic event, I'm Prodical Evanting roughly and any or other traumatic event.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1	1	fYes, specify Cuba I∐Yes 2∭∏No	Specify:	o Hican, etc.)	Specify.	k, White, 6	LACK		
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<u>la</u> n	Alental Alental rked o	To Be	HAILE MEZENGHI				LETEDIN	IGLE (	GHEBREMI	CAEL			
ary	and N is ma		19a. Informant's Name/Relationship (	Type. Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip	Code)		
≥,	and fealth m 27		TRACEY TITTLEY/				ON ȘTREET		SPRING, MARYLAND 209				
Ö	iges 1 nt of 1- iffite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	metery, cren	sition (Name of natory or other place		Date	20c. Location -	•			
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	permit Depar Impor any ir		21. Signature of Funcial Service Electron	Ja ll		7474 LAND					20785		
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	/Medical Examiner	П	resulting in death)  Due to (or as a consequence of):										
	LAdillilei	<u>-</u>	Sequentially list conditions, b. Due to /or as a conneguence of the conditions,										
	uted 1 Insit	Examiner	if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events	Due to (or as a conseque	Due to (or as a consequence of):								
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89 )	ertifica ling ph e as th	Med	IF FEMALE:						- 100				
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o	that the dended by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	am 5L	Other (specify) _							
<u>.                                    </u>	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a	by Ph	Part II. Other significant conditions of	ontributing to death but not result	ting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	bute to th	ne cause of death?		
rds	w requires been sign should be	ed b						1 🗆 Y	es 2□No	3 ☐ Prob	ably 📉 Unknown		
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of	Phys r this ral dir	2	1 ☐ Yes 2 ☒ No  27. Manner of Death	1   Inpatient 2   E		4 LI Nursing H	ome 54 Residence 6 ☐ Other (Sp			y)			
o	Attending Physician: or death. ector: After this certifici by the funeral director, p.	tion	1 → Natural 5 → Pending 2 → Accident investigation	(Month, Day, Year)	Date of Injury (Month, Day, Year)       28b. Time of Injury Work?       28c. Injury at Work?       2 Light State of Work?       2 Light State of Work?					28d. Describe how injury occurred			
Division of Vital Records,	₽₩₩₽	Certification: To	3 Suicide 6 Could not be determined	28f. Location (S City or Town		er or Rura	I Route Number,						
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	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed	(Month,	Day, Year)		
			D41978						JANUARY	13,	2009		
. 1	5		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)		<del>-</del>					
10			NADER TAWAKOLI 31. Date filed (Month, Day, Year)	M.D. 4000 MITCH	HELLVI	LLE ROAD	# A312 F	BOWIE, MAR	RYLAND	2071	6		
	Sta Registr		11. Date filed (Month, Day, Year)	32. Registrar's Signat	ares	•							

Amended Item 29d per Physician 01/16/2009 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Rosanna June Heiss January 14, 2009 8:03a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Dove House Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X 53 June 9, MD Director 216-66-9985 1955 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Baltimore Freeland 1 ☐ Yes 2 ▼No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21053 20108 Middletown Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify Specify: 9 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kelly & Associates data processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milford Heiss Evelyn Dandy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3810 Normandy Drive 2D, Hampstead, Md. 21074 Joyce A. Heiss, sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Salem United Methodist 1/16/2009 Hampstead, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License Lemmer 1 land 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy performed? Yes 2 No certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) MOVSE 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 □ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 \_\_ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \_\_ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature an 29c. License numbe P 29d. Date signed (2009) Pay, Year) ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad lavio hruter WASHINUSIG-, LID 21157 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Knews

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	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cib	y, Town or Lo	cation					100	d. Inside City Limits		
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	7		1 Hane	#/ Cul	y W		039	9190			January	19,	2009		
	(8)		30. Name and address of person	n who completed cau	ise of death (Iter	m 23a) (Type	, Print)								
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	St	ate	31. Date filed (Month, Day, Year	32.	Registrar's Sign	ature						,			
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17, 2009 7:02 Α CHARLES EDWARD HALL, SR. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mount Airy

If Under 1 Year If Under 24 Hrs. (Month, Day, Parks)

Navs Hours Min. (Month, Day, Sept. 4, Frederick Kline Hospice House 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** T936 Virginia 72 579-46-3098 Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Exeminer must be notified at 1 ∐Yes 2 No Director Thurmont Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21788 16177 Eyler's Valley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify Specify: þ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Operating Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie L. Marsh is merked Forrest Asia Hall P or other treumetic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
eny injury or other treu
once. 16177 Eyler's Valley Road, Thurmont, Maryland 21788 Neal Hall / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Eyler's Valley Cemetery 1/20/09 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. EAST MAIN STREET, THURMONT, MD 21788 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca Carhosis, unknown cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical metastases, unknown primary malignancy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physiclan/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes ed by the a P.O. 9□Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should thyrocdis 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy page perform Vital Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 After this 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Injury at Work? Medical Certification: or Attending Division Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident i Director: A 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after filled in t Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the 29c. License number 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 30. Name and address of pers OOPER 10 m.D strar's Signature 31. Date filed (Month, Day, Year) State JAN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15,2009 11:15a M January G. Horine Gloria /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 608 Wilson Place Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F Oct.16,1927 Maryland ( ) 81 Director 212-24-3548 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location event, the matural", or items 23a or 28a-f show event, the matural Expenses 1 Yes 2 No Director Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 608 Wilson Place United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify Completed by 3 Nidowed 4 Divorced White 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Mackley ၉ Charles E. Geisbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8926 Devilbiss Bridge Road, Walkersville, MD 21793 Willard M. Horine/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or Zion Lutheran Cemetery 1/21/2009 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pa V **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) physician ar s the burial-to O. Box 68760 Physician/Medical ast the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed of Vital Records. þ be 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autops, performed r Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate 1 ☐Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division injury 1 □ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the within 2

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 West 9th Street, Frederick, Maryland 21701 Austin Pearre M.D 31. Date filed (Month, Day, Year)

32. Registrar's Signature JAN 2

CITTLE

29c. License number

069189

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Day 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 Sally H. Joseph JANUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Lanham Doctors Community Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Days Hours 10/20/1956 52 Maryland 577-76-8987 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show Department of Health and Mental Hygiens in attural, or items 23a or 28a-f show any injury or other traumatic event, the Madical Every are out to inclining any injury or other traumatic event, the Madical Every are out to inclining at once. 1 Yes 2 No Director P.G. Bowie Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20720 U.S. A 11805 Lisborough Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  $\int_{0}$   $\int_{0}$   $\int_{0}$   $\int_{0}$   $\int_{0}$   $\int_{0}$  Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Black Specify: 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) HIV/AIDS College (1-4or 5+) 4 yrs Elementary/Secondary (0-12) Organization Executive Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ David Holloway Sallie Callaham မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Roberto E. Joseph/Husband 11805 Lisborough Rd., Bowie, Maryland Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l.Mem.Park 01/15/09 Laurel, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility ton & Sons Co., Inc. H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on \_\_\_ch line. Immediate Cause (Final cancer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation n 24 hours after death.

Reference Funeral Director: Aftered filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature

8118 Good LuckRd., Laxham,

death (Item 23a) (Type, Print)

mD.

			For	State of Maryland / Depa	artment of Health and M rtificate of Death		2000	02861
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	Physicia					Month Jan. 2	Day Year 2 2 2 2 0 0 9	4:16p M
	/Medic Examin		Ruth Ann John 4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	Udii - Z	4c. County of Death	7.100
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	Funeral			M 2□NF Vre	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	* *
	Director		Usual Residence of Decedent	59		1/26/4		
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	he Ma 28a-f s	Directo	MD P.G.	Oxon Hi	10f. Zip Code	1	0g. Citizen of What Cour	
	with t		10e. Street and Number 148 Onondago D	)r	20745	'	U.S.A.	
	death ms 23	Funeral			Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
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altimore,	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	ection Cem. 1/27	7/09 C	linton,Md	•
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licens	ge 25	2 Name and Address of Facility Hoo	dges an	d Edwards	
	707 # 0		MINICOLO POR PORTO	lications that caused the death. Do not en	910 Silver hill	Rd. S	Suitland, M	d_20746
		N 1	shock, or heart failure. List only o	ne cause on each line.		or respiratory and	oot,	Approximate Interval Between Onset and Death
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о П	the at	/sici	1 ☐Yes 2 ☐No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 [ 9 ☐ Unknown	Other (specify)			<i>Ju</i> ,
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Vita	sician: The certificate rector, pag	å	25. Was case referred to medical examiner?	Hospital:	26. Place of Death			
Division of Vital Records,	Phys er this eral di	5	1 Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury 28b. Time of	of 28c. Injury at		ence 6 Other (Speci	fy)
ion	ath. r: Afte	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	Work? M 1 □ Yes 2 □ No			
<u>six</u>	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or Run n, State)	al Route Number,
	oital o		29a. Certifier 1 Certifying Phy	ysician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the	eauco(c) and manner as	stated
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it.	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, o	late and place, and due t	o the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	. 1	29c. License number	2	9d. Date signed (Month,	Day, Year)
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				completed cause of death (Item 23a) (Type,		0 - 14	4.15	1/422
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Registrar

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	Funeral		5. Social Security Number 6. S	Sex 7. Ag	ast birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	irth			lace (State try)	or Foreign	
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	er dez items ner m	Funeral	11. Maritai Status	12. Was Decedent Armed Forces?		3. 13.	Was Deced f Yes, spec	lent of His cify Cubar	spanic Origin? (S n, Mexican, Puer	specify Yes or N to Rican, etc.)	0-		- Americ k, White,	an Indian, etc.	
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	lent's Usua	al Occupa	ation	rkina	16b.	Kind of Bu	siness/Ind	dustry	
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			CAROL K. MILLER/I	AUGHTER					HILL D		AGER	STOWN	L MD	217	42
ore	Pages 1 nent of H int: If Iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State		ace of Dispo emetery, crer			e) ¦	Date	20c. l	Location -	City or To	wn, State	
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			23a. Part . Enter the disease, of com- shock, or heart failure. List only	plications that caused one cause on each li	the death	. Do not ent	er the mode	e of dying	, such as cardia	c or respiratory	arrest,	moro,	, FID	Approxima Interval Be	te
84	Physician		Immediate Cause (Final disease or condition	_a.		9 (	cno	C.~						Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									
		ē	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequ	ence of):									
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C											
ó,	e exec ian an urial-tr	Exa	resulting in death) Last	Due to (or as	a consequ	ence of):									
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d											
Box 6	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						_		23d. Date	e of delive	nv	
	death e atte	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant a			Ectopic pro Other <i>(sp</i>					Mor			Year
P.0	at the by the	hys	9 ☐ Unknown	9□Unknown											
	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions	contributing to death b	ut not resu	lting in the ur	nderlying ca	ause give	n in Part I.					e cause of ably 4 $\square$	
or Vital Records,	requi	Completed										<u> </u>			
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ta	an: T tificat tor, pe	Be Co	25. Was case referred to medical						26. Place of Dea	1  Yes ath (Check only		lo 1	□Yes	2∐ No	
ľ	nysicl nis cer I direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 E	R/Outpatien	t 3 🗆 DO	Othe		lome 5 ☐ Res	,	6 □Othe	er (Specify	1)	
o u	Ing Pi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work		28d. Describe	how inj	ury occurre	ed		
Division	death ctor: ,	icati	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of ini	ury - At hor	ne, farm, str	M eet, factory		res 2□No	28f. Location	(Street a	and Numbe	er or Rura	l Route Nur	mber.
Θį	al or A s after af Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	)				City or To	wn, Sta	te)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicai Exam	nysician: To the best miner: On the basis o and manner st	of examinati	vledge, death ion and/or in	occurred vestigation,	at the tim , in my op	ne, date and place pinion, death occi	e, and due to the urred at the time	e cause( e, date a	s) and mai nd place, a	nner as st and due to	ated. the cause(	s)
	To the within To the comple	Med	29b. Signature and title of certifier	and marrier at			290	License	number		29d. D	ate signed	(Month, i	Day, Year)	
			Michael 6	Milam	( .	ND		04	1667			1/2	2/0	9	
NA	1-4		30. Name and address of person who					,	1	^	,	1	,	n M.	
		to.	Michee A 31. Date filed (Month, Day, Year)	32. Registr		1/1/C	, N	10 d	ical (	comes	1	Rice	2 Na	n M.	0.
	Sta Registr		IAN 2.3.2			4 4		,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Everett Kinsman Simpson 2009 14, 5:00 A M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Bethesda Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min. 577 20 5214 Director 86 July 7, 1922 DCUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Its Medical Exprining must be notified at 10d. Inside City Limits Director 1 ∏Yes 2 No MDMontgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12006 Gatewater Drive Funeral 20854 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of Elementary/Secondary (0-12) College (1-4or 5+) Organist/Choir Director Washington 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orland Samuel Kinsman Mary Esther Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau once. Mary Margaret Fitzgerald/Sister 12006 Gatewater Dr., Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven 01/22/2009 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final **Physician** Multiorgan Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Parkinson's Disease Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Dise to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Aspiration Pneumonia Months resulting in death) Last Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Ye ar 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Arthritis Dsyphagia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate 1 ☐ Yes 2 🖼 No 1 ☐ Yes 2 □No 124 hours after death.

18 Funeral Director: After this certific pletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4√ Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tuli MD 3503 Perry St. Raman R. #B Mt. Rainer, MD 20712 31. Date filed (Month, Day, Year) State JAN 16 Registrar

Division or Vital Records, P.O. Box 68760,

			se Type or State o			<b>delible Ink.</b> artment of H				_	ible.	
		For State Registrar		······································	•	rtificate of			, ,	eg. No. 2	109	02865
Physicia	an	1. Decedent's Name (First, Middle Annie Laurie F							2. Date of Dea Month	Day	Year	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town, or	r Location	of Death	January		2009 y of Death	6:00 p M
Examini	eı	Citizens Nursi		,		Frede	rick			F	reder	ick
Funeral Director		5. Social Security Number 238–26–8186	6. Sex 1 ☐ M 2 🔀 F	7. Age (In y	rs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 26	Year)	Cou	place (State or Foreign ntry) NC
rland ow at		Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	ocation						10d. Inside City Limits
a-f sh	ctor	MD Harf	ford		Bel A	ir						1 ☐ Yes 2 No
or 28 be not	Director	10e. Street and Number	G.			10f. Zip Code	7 .		1	0g. Citizen of		ntry?
eath v ns 23a must	Funeral	708 E. Farrov	,	edent Ever in	U.S. 13.	210. Was Decedent of H		igin? (Sp	ecify Yes or No-		USA ce - Americ	can Indian.
after d		1 ☐ Never Married 2 ☐ Man	Armed F	orces? 2 <b>⋉</b> No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexicai Specify:		Rican, etc.)	Bla	ick, White,	
ural",	d by	3  Widowed 4 □ Divorced	Year or I	Dates:						Specif	MITT	
in 72 h	olete	(Specify only highe	t's Education st grade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during mos d)	st of work	ing	16b. Kind of B	Business/In	dustry
d with giene.	Completed	Elementary/Secondary (0-12)	College	1-4or 5+)		Seamstre				Legget	t's D	ept Store
be file tal Hy d othe	Be C	17. Father's Name (First, Middle,							(First, Middle, i		,	
hould d Men marke matic	ဥ	Edward H. Holl			19h Mailir	ng Address (Street			Washingt			
nd 2 slutth an ulth an 27 is r		Michael T. Kund				E. Farrov						Code
of Hee		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	· · · · · · · · · · · · · · · · · · ·	20b	p. Place of Dispo cemetery, cre	osition (Name of matory or other place	ce)	)1/19	<b>≠</b> 2009	20c. Location	- City or To	own, State
ment ment tant: If		4 ☐ Donation 5 💽 Other (S	Specify) Entomb							Finks		MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Iniportant: I file X1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee			Fitts Fu 12 Washir						21157
555-41	- 1	23a. Part1. Enter the disease, or	complications that	caused the de						_	, MD	Approximate
Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on	each line.	NEU	MOLY	TA	)				Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a cons								1/10/-3
	e	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to	(or as a cons	equence of):						-	
xecuted and I-transit	xaminer	that initiated events c.										
0 ⊏ 0 0	ш	resulting in death) Last	Due to	(or as a cons	equence of):							
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leath certific attending pl	M/ui	IF FEMALE: 23b. Was decedent pregnant	b. Was decedent pregnant 23c. It yes, outcome pt pregnancy 23d. Date 23d. Date								ate of delive	ery
ie deat	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nant at time of		Other (specify)				M	onth	Day Year
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The law requires that the death certificate be the has been signed by the attending physician oage 2 should be detached for use as the bur	ed by								1 □ Y	es 2 Alo	3 ☐ Prot	oably 4 □Unknown
law re as bee	Completed								24a. Was a	n 24b.	Were auto	ppsy findings available mpletion of cause of
	Con							_	perfori 1□ Yes	med?	death?	2 □ No
Physicien: Th r this certificate ral director, pag	Be c	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ Mo	Hospital:	Inpatient 2	☐ ER/Outpatier	oth Oth		77.52	n (Check only on			
ig Phy ter this	n: To	27. Manner of Death	28a. Date		28b. Time o				me 5 Reside			9/)
Attending r death. ector: After by the fune	catio	1	gation			M 1 🗆	Yes 2□	No				
or At after d Direct	Certification:	4 Homicide determ	nined 28e. Plac build	e of injury - At ting, etc. (Spe	t home, farm, sti ecify)	reet, factory, office			28f. Location (St City or Town	treet and Numi n, State)	ber or Rura	al Route Number,
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Co	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To th Examiner: On the land man	e best of my loasis of exam	knowledge, deat ination and/or in	h occurred at the tire tire tire to the ti	me, date ar opinion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) and m late and place,	nanner as s , and due t	stated. o the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certified		5		29c. Licens	e number	<u></u> ЦП	2	9d. Date signe	ed (Month,	Day, Year)
MIL		30. Name and address of person	who completed cau	se of death (I	tem 23a) (Type,	Print)			Cada	Junua	91	7,001
Sta	te	31. Date filed (Month, Day, Year)	32.1	Registrar's Sig	gnature g	NE STE	H-7	$r_1$	ecser CK	, MU	de	IUI
Registr		JAN 1	5 2009 /	Eneva	A. A	barker						
HMH 17 Rev 1/2	001				- 6							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 6, 2009 11:00<sup>a</sup> George Harry Knudson, Jr. January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Charles Waldorf 10503 Lynnewood Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 12/25/38 Hours Country) 1 📉 M 2 🗆 F 70 235-60-1033 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Merritt Island Brevard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 32952 USA Island Cswy#2499 779 E. Merritt 12. Was Decedent Ever in U.S. Armed Forces?

15 Yes 2 No If Yes, Give Year or Dates 60 - 84 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo SpecifyWhite 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Dep. Chief Security Police U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chura George H. Knudson, Sr. Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10503 Lynnewood Ct. Waldorf, MD. 20601 Michael L. Knudson/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Arlington Cemetery 3/5/09 Fort Myer, VA. 4 Donation 5 Other (Specify) 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 21. Signature of Funeral Service 2294 Old Washington Rd. Waldorf, MD. 2060 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Lung Cancer Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director FL

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mine.

attending physician and for use as the burial-trar

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical s been signed by the should be detached þ Completed has page 2 s certificate Be မှ After this funeral Certification: ours after death.
neral Director: A

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. was autopsy performed?
Yes 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 ☐ Yes 🍇 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined

within 24 hours a To the Funeral I Hospital

ö

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur MD

PO Box 2729

LaPlata, MD. 20646

Son's

29d. Date signed (Month, Day, Year)

1/16/09

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D28352

09-00166	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Hendrikus Joseph Kuster	State of Maryland / Department of Health and Mental Hygiene
1. For State	

		1- For State Registrar Certificate of Death	Reg	. No. 200	9 0286
Physici Medical Exam		HENDRIKUS J. A. Kusters	2. Date of Death Month I January 6, 2	Day Year 2009	3. Time of Death 1243 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2152 Blue Ball Road Elkton		4c. County of Death Cecil	
Funeral Director		5. Social Security Number  3. Age (In yrs. last birthday)  1. Age (In yrs. last birthday)		(MM/DD/YYYY) 9. Bir 30,1956 Foreig	
, any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show Lat once.	tor	MD. CECIL ELKTON	L <sub>k</sub>		1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	ral Director	2152 Blue Ball Road 21921		Citizen of What Cou	ntry?
r death wi or items	Funera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	White, etc.	can Indian, Black,
urs afte tural",	d by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of wo	ork done	Specify: W	hite.
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygies. T's marked other than "natural", or items 23a or 28a-f 5the mustic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  PiPe-Fi+teR		Steel	
ID 21215-00: should be filed with and Mental Hygiene 77 is marked other ti	Be Cc	17. Father's Name (First, Middle, Last)  18. Mother's Name (  18. Mother's Name (	First, Middle, Ma	aiden Surname)	N. W
2121 chould be find Mental I is marked atic event,	To E	HENDIK Hubert Joseph Kusters HENDI  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	Iral Route Number	er, City or Town, State	, Zip Code)
, MD and 2 sho saith and em 27 is raumati		MANY Kusters/WIFE 80REGON ROAD W  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, 1/2)  20c. Method of Disposition (Name of cemetery, 1/2)	ILMING	TON De.	19808
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other trau		1 Burial 2 Cremation 3 Removal from State	Date	20c. Location - City or	Town, State
Baltin permit. Pa Departmer Importani		1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	N. 4,09	NEWHIA	LUCCHWAIC
		STANOFFECKET FU	Neinlh	OME NEWA	IK DELAWARE
Physician / /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as derdiac or refailure. List only one cause on each line.	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. <u>Tramadol intoxication</u> Due to (or as a consequence of):			Death
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
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760, cate be executed physician and the burial - trans	Medica	$\chi$ UNPENDED $\square$ AMENDED 23a,27,28a-f, perME, G888 2/6/9	09 TT		
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ov.	23d. Date of delivery	pay Year
ox atter	sician/	1 Yes 2 No 9 Linknown 4 Pregnant at time of death 5 Other (Specify)			idy Teal
the c	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
- S . 60 e	d by		1 Yes	2 🖊 No 3 🗌 Prob	ably 4 Unknown
Division of Vital Records, and or Attending Physician: The law requires after death.  al Director: After this certificate has been seled in by the funeral director, page 2 should be	Completed		24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
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Vital hysician: this certif	Be C	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing		esidence 6 🗸 Other	Scene
ing Phy After th funeral	<u>ان</u> 1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		winjury occurred Sul	
Sion Attend death. ector:	catio	Pending Fd 1/6/09 Fd 12:43 am 1 Yes 2X No processing Pr	rescript	ion medica	ation
Divi	Certification	3 X Suicide 6 Could not be determined Could not be determined (Specify) found at home I	8f. Location (Stre or Town, Stat E1kton M	eet and Number or Ru e) 2152 Blue	al Route Number, City Ball Rd
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the date of the date	ue to the cause(s	s) and manner as state	d. cause(s)
F × F 3	ĕ.	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mor	th, Day, Year)
		O.C.M.E.		January 7, 2009	
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medica! Examiner 111 Penn Street, Baltimore, MD	21201		
		31. Date filed (Month, Day, Year)  32 Registrar's Signature			
Regist	rair	FEB 0 3 2009 Musua B. Garle			

DHMH 17 Rev 1/2001 OCME 2006

OCME

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year 6:30 P.M Kathleen В. Link January 14 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Montgomery Gaithersburg 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 👿 F 93 218-52-7048 March 24,1915 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 No 1942-If Yes, Give Year or Dates: 1946 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: 3₺ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Todd Barber Elsie Kennedy 0scar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leora L. Caporaletti/Daughter 6009 Snow Crystal, Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/15/2009 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

a or ns 23a

"natural", or Items

the Medical

Pages 1 and 2 should be filed wi ent of Health and Mental Hygien nt: If Item 27 is marked other th ry or other traumatic event, the

permit. Pages 1
Department of H
Important: If iter
any injury or ott

Director

Funeral

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Completed

Be မ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner burial-tran Physician/Medical ed by the a detached f signed by Completed by Be Medical Certification: To

filled in by the

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours after death To the Funeral Director: To the Hospital completely 5 +1

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of delivery Month Day Year		
Part II. Other significant conditions of	ontributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Atunefiler	ellation Aype	rtensin	1 Yes 2 No 3 Probably 4 Unknow
	Lemia Spina hereseentary+	elsterrois a Neshiscler	24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	1	-	th (Check only one)
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Mann → of Death 1 → atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowledge, death niner: On the basis of examination and/or inve	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

29c. License number

04/15

CAITHERSBURG, MI

29d, Date signed (Month, Dav. Year)

LACBERT BIRSCHBACK 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 12USSELL AUSIULIE

226/2

			1 - For State Registrar	State of M	laryland / Dep	artment of rtificate of		-	0000	00060
			Decedent's Name (First, Middle, Last	t)		rineate or	Death	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physic /Medi		Lorena Mae	LE	STER			Month	Day Year	53 A
	Exami		4a. Facility Name (If not institution, give		)	4b. City, Town, o	or Location of Deat	-	4c. County of De	
Arts.	Francis		16306 McGregor  5. Social Security Number 6. Se		ge (In yrs. last birthday,	Hager If Under 1 Year	stown I_If Under 24 Hrs.	Dete of Bird	Washin	
	Funeral Director		,		70 Yrs.	Months Days	Hours Min.	(Month, Day	(, Year)	rthplace (State or Foreign Country) est Virginia
	pui "		Usual Residence of Decedent  10a. State 10b. County						<b>,</b>	
	Maryla f sho	ō	VA Arling	ton	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-	irect	10e. Street and Number			10f. Zip Code		T	10g. Citizen of What C	
	th with	at D	4820 S. 14th St.			22	204		USA	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show safed Examiner must be muffled at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:	No I	Was Decedent of I If Yes, specify Cub 1 □Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Dece	dent's Usual Occup	pation during most of wor	kina	16b. Kind of Business	s/Industry
121	within and the than the than the than the than the than the the than the the the the the the the the the the	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retire	Assistar		Arlington	County
d 2	filed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		(100,102)	o o c a o c			Maiden Surname)	, coursey
/lan	uld be Menta arked atic ev	To 18	Harold Jones					a Jarrel	,	
, Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, Its Medical once.		19a. Informant's Name/Relationship (7) Nellie Winck/Siste		19b. Mailii 16306	ng Address (Street McGrego	and Number or Ru r St. Hag	ral Route Numbe gerstown	r, City or Town, State, MD 21740	Zip Code)
Baltimore,	of He		20a. Method of Disposition 1	Campual from Chair	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	ce)	Date	20c. Location - City or	Town, State
Ë	t. Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		High Lawn	Mem. Park	1/17	7/09	Dak Hill, V	West VA
Ba	permi Depar Impor	10 0	21. Signature of Funeral Service sicens  Marine 1	hn		Name and Addre		lson Blv	d. Arl., V	A 22203
	Control of the price of the pri	Examiner	23a. Part1. Enter the disease, or compishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as	a consequence of):  a consequence of):	Corcin		or respiratory arr	est,	Approximate Interval Between Onset and Death 3 MUARY
Box 6	death certi e attending d for use a	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3 time of death 5	Ectopic pregnanc	,		23d. Date of de Month	livery Day Year
Ś,	ires thi signed I be de	<u>۾</u>	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the ur	derlying cause give	en in Part I.		acco use contribute to	
õ	w requir been s should	eted						1 ∐ Ye	s 2 <b>2 1</b> No 3 □ Pi	robably 4 Unknown
	The larate has	e Completed	25. Was case referred to medical				26. Place of Deat	24a. Was ar autops perform 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of 2 □No
	is is	2 B	examiner? 1 Yes 2 No	ospital: 1 🔲 Inpatie	nt 2 ER/Outpatien	t 3 DOA Othe			nce 6 🖾 Other (Spe	isterisence
ב	ding P h, After i funera	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	ry 28b. Time of Injury	28c. Injur Work		28d. Describe ho	w injury occurred	
DIVISION OF	lo the Hospiral or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	ertification:	2	28e. Place of Injubuilding, etc	iry - At home, farm, stre :. (Specify)		Yes 2 □No	28f. Location (Sti City or Town	reet and Number or Ru , State)	ural Route Number,
:	Io the Hospital or All within 24 hours after of To the Funeral Direct completely filled in by	edicat C	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination (Check only one)	sician: To the best oner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
1	vithir To th comp	Me	29b. Signature and title of certifier			29c. License			d. Date signed (Monti	
			Muchael of	Whowen	LMD	04	1667		1-13-	09
	15		30. Name and address of person who co			Print)			1/ ,	og
	Stat	e_	31. Date filed (Month, Dev. Year)	32. Resistra	r's Signatur	Meal	ce ( ()	hoper	1025cust	Dun MO
	Registra	ır	JAN 1 5 2009 Year)	wer &.	gar.					

State of Maryland / Department of Health and Mental Hygiene 02870 1 - For State Registrar Reg. N 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 12, 2009 MARGARET MAE LYNESS 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🕱 F 200-24-3539 76 FEBRUARY 17, 1932 Director PENNSYLVANIA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f show the Medical Expreien must be notified at Director 1 ☐ Yes 2X No PENNSYLVANIA ALLEGHENY **PITTSBURGH** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1204 SKY RIDGE DRIVE 15241 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: <u>ک</u> Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE PUBLIC HEALTH it of Health and Mental Hygir If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) JOHN HENDERSON KATHRYN HOLSTEIN ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE EDWARD LYNESS/HUSBAND 1204 SKY RIDGE DRIVE, PITTSBURGH, PENNSYLVANIA 15241 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ott JANUARY 13 2009 CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Lice Will Eron M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and De Immediate Cause (Final disease or condition resulting in death) **Physician** orc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami the burial-tran Due to (or as a consequence of): P.O. Box 68760. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 € No 23d. Date of delivery 3 Ectopic pregnancy Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 □ Yes 1 ☐ Yes 2 000 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Yes 1 Datient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely 2 Medical Ext and manner stated within 2 29b. Signature and we of certifi 29d. Date signed (Month, Day, Year) 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month egistrar's Signatu State Registrar

			For State		State of Ma	aryland /		tment of F ficate of t		l Mental	, ,	0000	
			Registrar  1. Decedent's Name	e (First, Middle, La	nst)		Certi	ilcale of i	Dealli	2. Date	Reg. N of Death	. 2000	3. Time of Death
	Physici /Medi	cal		SARET	EVELYN ve street and number)	LEV		b Oth Town	al aution of B	JANU	ARY 19		5-30 P M
	Examir	ier	Kline	Hospic	,		4	90	Location of Dea	ath		c. County of Death Fredericl	
	Funeral		5. Social Security No. 215 ·26 - 19	umber 6.		e (In yrs. last bi			If Under 24 Hi	rs. 8. Date n. (Mon	of Birth th, Day, Year 25 : 19		place (State or Foreign
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	irylan show	-	10a. State	10b. County		10c. City, Tow	n or Locat	ion					10d. Inside City Limits
	he Ma 28a-f	ecto	Maryland	Frederi	ck	Mid	dleto						1 X Yes 2 □ No
	a or 2	Funeral Directo	10e. Street and Num		0.			10f. Zip Code				itizen of What Cou	,
	ms 23	era	11. Marital Status	shington	12. Was Decedent 8	ever in U.S.	13. Was	2.1769 Decedent of H	ispanic Origin?	(Specify Yes		ted State  14. Race - Amer	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Exament and the matthed at	b	1 ☐ Never Marrie	_	Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates:			es, specify Cuba	ispanic Origin? and Mexican, Pue Specify:	erto Rican, etc	ē.)	Black, White,	
15-	"natu	lete	(Speci	15. Decedent's E ify only highest gr	ducation ade completed)	16a	. Deceden (Give kin	t's Usual Occup d of work done o	ation furing most of wi	orking	16b. F	Kind of Business/Ir	ndustry
12	within iene.	Completed	Elementary/Secon	ndary (0-12)	College (1-4or 5			store o	•		Or 1	rocery	
br	e filed al Hygi other vent,	BeC	17. Father's Name (	First, Middle, Last	)				18. Mother's Na	ame (First, M			
/lar		To E	Edgar	<b>S</b> -	Har	gett			Beatr	ice M	[ ]	Houff	
Jar			19a. Informant's Na		**						lumber, City	or Town, State, Zi	p Code)
e, l	l and Heat		Patricia  20a. Method of Dispo		daughter				/ Myers		MD	21773	
Baltimore, Maryland	t. Pages rtment of rtant: If it		1 X Burial 2 ☐ 4 ☐ Donation	Cremation 3 ☐ 5 ☐ Other (Specia	-	Mount	01iv	on (Name of ory or other place ret Cem	JAN		9 Fre	derick l	Maryland
Bal	Depa Impo any Ir		21. Signature of Fur	neral Service Lice	nsee	,)						eral Home	
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68760,	ficate be executed i physician and s the burial-transit	dical			d								
99	rtificat ng phy as the	ledi			<b>L</b> u	-	***						
Box	w requires that the death certific been signed by the attending should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent		23c. If yes, outcome of		3 ∏ Fo	topic pregnancy	,			23d. Date of deliv	ery
О.	ne dea the at	/sici	in the past 12 n 1 ☐ Yes 2, ☑ 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown			her (specify)			_	Month	Day Year
P.O.	that thed by detacl	Phy		cant conditions	ontributing to death bu	t not resulting in	n the under	lvina cause aive	n in Part I	23e	Did tobacco	use contribute to t	he cause of death?
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ital	lan: '	Be C	25. Was case referre	ed to medical					26. Place of De		es 2,⊠No nlv one)	1 □Yes	2/1No
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o u	ing P	ion:	27. Manner of Death 1 ☑ Natural	5 Pending	28a. Date of Injur (Month, Day)	y Year) 28b. 1	Time of njury	28c. Injury Work		28d. Desc	ribe how inju	ry occurred	· · · · · · · · · · · · · · · · · · ·
isio	ttend death stor: , the f	icati	2 ☐ Accident 3 ☐ Sulcide	investigation 6 ☐ Could not be					′es 2□No				
Division of Vital Records,	tal or A s after al Direc ed in by	Certification: To	4 ☐ Homicide	determined	28e. Place of Injurbuilding, etc.	y - At nome, ta (Specify)	rm, street,	factory, office		28f. Locati City o	on (Street ar r Town, State	nd Number or Rura e)	al Route Number,
:		Medical	29a. Certifier 1 (Check only one)	Certifying Ph ☐ Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination an	e, death oc id/or invest	curred at the timing ation, in my op	ne, date and plac pinion, death occ	ce, and due to curred at the t	the cause(s ime, date an	s) and manner as s d place, and due to	stated. o the cause(s)
i	vithi To th	ž	29b. Signature and ti	tle of certifier				29c. License	number		29d. Da	ite signed (Month,	Day, Year)
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	0		30. Name and addres	ss of person who	completed cause of de	1 1 -	1	4 01 1	m 1 3	), C			
	Stat	e_	31. Date filed (Month		32. Registra	's Signature	- / 1/1/	delletown	1-10 61	(6)			
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 02872 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ann D. Loebach 1/17/2009 /Medical 1:45  $P^{M}$ 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Renaissance Gardens (Riderwood) Silver Spring Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) 10/7/1919 Birthplace (State or Foreign Country) Days 1 ☐ M 2 🛛 F Hours 010-05-6236 **Director** 89 Cambridge, MA Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City. Town or Location or 28e-f show 10d. Inside City Limits Director Prince George's 1⊠Yes 2 No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 3160 Gracefield Road Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ont: If item 27 is marked other then "netural, or Items 23s ary or other treumatic event, the Madical Examinar auth 20904 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2⊠No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Drohan 2 Hanna Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catloth / Sister 2704 Lackawana Place, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 TCremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 1/21/2009 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility 4739 Baltimore Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) **Physician** Cellulitus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia, Osteoporosis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physiclen: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 1/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio Machado, 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 2 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Pertale of Cass 2/20/09 TH Department of Health and Mental Hygiene 02873 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Frances Meyers 3:00 PM MYERS FRANCES 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ousta Hospice at omico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign. Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours Min. 65 141-34-1221 BURLINGTON, NJ MAR 07,1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND WORCESTER OCEAN CITY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 163 PINE TREE ROAD 21842 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOHN TROTTO** ANGELINA **MATARESE** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAUGHTER) WARFIELD 163 PINE TREE RD., OCEAN CITY, MD 21842 DAWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA JAN 25,2009 DELMAR, DELAWARE 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Funeral Service Lice 6 MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease r domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINDUMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 poinths?

1 Yes No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 1 ☐ Yes 2 **21** 26. Place of Death (Check only one)

**Physician** /Medical Examiner Physician: The law requires that the death certificate be executed

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After this funeral dir

spital or Attending P nours after death. neral Director: After i y filled in by the funera

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

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Certification: To

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permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau

Frances Theyers Baltimore, Maryland 21215-0036

or other traumatic event, the Medical Examiner must be notified at

ē Exami Physician/Medical IF FEMALE:

> 25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

P.O Dup 1733 SACIONING UND 21802

Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE

29a. Certifier

27. Manner of Death

1 Natural 2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and tittle of certifier

D0058410

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHUMM WARY COASTAL HOSPICK 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Charles Harold Meredith January 18 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner aston albot ne movia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Maryland 11 M 2□ F 221-18-9626 78 July 20, 1930 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MDCaroline Denton Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21629 6421 Federalsburg Highway United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White þ 3 Widowed 4 Divorced 47-67 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Hospital Medic United States Navv 11 (Grad.) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman Meredith Helen Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other Florence Meredith/Spouse 6421 Federalsburg Highway, Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State trial 2 ☐ Cremation 3 ☐ Removal from State Concord Cemetery 4 Donation 5 Dother (Specify) 01/22/09 Denton, Maryland 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** 5 days /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ed by the attending physician detached for use as the burlal Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Ö 9 I Inknown 9 Unknown signed by to σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. DIABETES 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Eglseder Easton, 503 Cynwood 1) Rive Luawi9

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 2 U 2009

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32 Registrar's Signature

Meredith

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\mathbf{1} = \mathbf{\hat{N}}_{\text{State}}^{\text{For}} 1/12/09$ , MS, Kent Co. Amended#2 02875 Certificate of Death 2. Date of Death 01 / 04 / 2009 1. Decedent's Name (First, Middle, Last) **Physician** 1623 larieric /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 13aH, more 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 3 / 5 / 1 9 3 8 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 27 F Months Days Hours 219-34-2922 70 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No MD Queen Annes Chestertown 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? 21620 USA 2219 Pondtown Funeral Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black Specify: Completed by 3 Widowed 4 Noivorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene.

27 Is marked other than 'r traumatic event, une me Elementary/Secondary (0-12) College (1-4or 5+) Lineworker Playtex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Pritchett Ida Wiggins မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. Michelle L. Young/Daughter 454 Smyrna Clayton Blvd Smyrna, DE 19977 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Mt. Pleasant Cem. 1/10/09 Pondtown, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BE Bennie Smith FH 717 W. Division 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -logalh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 11 Due le or as a consequence of) Physician/Medical Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) ed by the a 9 HInknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 2 🗆 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

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M.

MD

5.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

AU =1176435 DI5813

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ROBERT JOSEPH McCARTHY 01 09 10 10:07 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 32217 Park Avenue Queen Anne, MD Talbot If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 3 / 1 6 / 1 9 2 2 Birthplace (State or Foreign Country) Sex XXM 2□ F Days Hours 018-14-0517 86 MA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Wes 2 □ No USA. MD Talbot Queen Anne, MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32217 Park Avenue 21657 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1. Yes 2 | It Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 ☐ Yes XIXNo Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Foreign Service US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Ale McCarthy Ella Theresa Shea 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shea McCarthy, daughter 32217 Park Ave., Queen Anne, MD 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Direct Crematory 01/13/09 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign lure of Funeral Service Licen-Bennie Smith FH. Worton, 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 085 RUC RONTC disease or condition resulting in death) Due to (or as a consequence of): CORUNA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 □Other (Specify) 2 □ ER/Outpatient 3 □ DOA 1 ☐ Inpatient 28d. Describe how injury occurred

requires that the death certificate be executed Box 68760. P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or Items 23a or 28a-f shedical Examiner must be notified

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Completed

filed within 72 hours after death with Hygiene.

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical once.

Physician

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Examiner

Baltimore, Maryland 21215-0036

Physician/Medical signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by peen has page 2 certificate or Attending Physician: director, 25. Was case referred to medical examiner? Medical Certification: To Be 1 Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 5 Pending 1/18 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,



11

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth Lee McGinley 19 2009 2:10 a. M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Dorchester Cambridge if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 098-30-8026 87 Director Sept. 3, 1921 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show "natural", or items 23a or 28a-f shov dicai Examlner πust be notified at MD Dorchester Cambridge 1 Yes 2 □ No Director death with the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 100 Glenburn Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify white Specify: þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any highy or other traumatic event, the Medical Exagn. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 11 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Brown Frank Cotton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geoffrey Barger son 100 Glenburn Ave., Cambridge, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 Removal from State Salisbury Crematory 1/20/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ZWEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ≥ ae 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2**X** No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28h Time of s after death. 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certification: 5 Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble Street Cambridge MD 21613 Ohnson DO atricia 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Woodrow Wilson January 14 2009 3:00 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours March 4, Director Maryland 214-07-7658 95 1913 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Dorchester Cambridge 1 XYes 2 □ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Glenburn Avenue 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 🏖 No Specify: white ρ Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manager grocery store 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be E. Mack Moore ဥ Nettie Virginia Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health ai Important: If item 27 is any Injury or are Richard W. Moore Jr. 207 High St., Cambridge, MD grandson 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Old Trinity Churchyard 1/17/09 Church Creek, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rena Tailu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 □ Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be executed Box 68760. P.0. Division or Vital Records,

burial-tran attending physician the use as t signed by the a d be detached for page 2 should certificate has funeral director After this To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After the filled in by

Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

28a-f

or Items 23a or

"natural"

is marked other than

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

0059973

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO Johnson

100 Bramble Street Cambridge, MD 21613

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Luke Harrison Messick January 10 2009 9:30 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 406 Talbot Avenue Cambridge Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☑ M 2 ☐ F 218-20-4770 85 26 1923 Jan. Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits MD Dorchester M Yes 2 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Talbot Avenue 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify. white 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Specialist First Class National Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luke Harrison Messick Marguerite Hurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris C. Messick wife 406 Talbot Ave., Cambridge, MD21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Maryland Veterans Cem. 1/14/09 4 □ Donation 5 □ Other (Specify) Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last 70 semi o Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year er (specify) ing cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 201No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 25 No 1 | Inpatient 2 ER/Outpatient 3□ DOA 5 Desidence 6 □Other (Specify) 27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Araturai

**Physician** /Medical Examiner

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

Completed by

Be

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

should be filed within 72 hours after of the Mental Hygiene, a marked other than "natural", or item

n and Mental

Pages 1 and 2 s ment of Health an ant: If item 27 Is

Baltimore, Maryland 21215-0036

death with the Marylar

and use as the burial-trai attending physician ó sate has been signed by the page 2 should be detached certificate director, this

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760

funeral After after death. filled in by the

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Oth
art II. Other significant condition	ns contributing to death but not resulting in t	he underly

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2	1 ☐ Yes 2
Sertification:	27. Manner of D  1 Statural  2 Accident  3 Suicide  4 Homicide
edical (	29a. Certifier (Check only one)
ž	29b. Signature a

6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Tyes

29b.	Signature	and	title	0
		C	n	t

of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Zugene 31. Date filed (Month

Porcheste distrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours a Hospital

To the Fune

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** MAY Year RAYMOND 2009 Januar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day. **Funeral** Year) 1 AM 2□ F Months Days Hours Min FREETOWN SIERRA 88 216-21-8234 Director JULY 24 1920 Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it we first Exactinational to another once. Director 1 XYes 2 No UPPER MARLBORO PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 USA 11511 HOMESTEAD DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ò If Yes, Give Year or Dates: Specify Specify: BLACK 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUS OPERATOR GOVERNMENT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOUSING DAISY **TSRAEL** MAY ္ဝ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12637 BLACK SADDLE LANE GERMANTOWN, MARYLAND 20874 JOSEPH MAY/SON Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATIONAL CEMETERY 1/24/2009 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funefal Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed クモシナし burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ρ in the past 12 months? Month Dav Year 5 ☐ Other (specify) P.0. the 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 The 2 No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Il Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day,

D. George

7500 Hanovertarkway

MDD58182

29d. Date signed (Month, Day, Year)

, Sui reici A, Greenbelt, MD. 20770

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID.

			1 - State of Marylar	id / Depa	artment of I	Health and Death		jiene eg. No. 2009	02881
	Dharis		1. Decedent's Name (First, Middle, Last)			<del> </del>	2. Date of Deat	th .	3. Time of Death
	Physici /Medio		Thomas Dowell McAvoy, Jr.				Jan.	10, 2009	5:09 P M
	Examir		4a. Facility Name (If not institution, give street and number)			or Location of Deat	n	4c. County of Death	
_			Anne Arundel Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs.)		Annapo]			Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 1 № 1 1 № 1 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Yrs.	If Under 1 Year Months Days		(Month, Day,		nplace (State or Foreign Intry) District
			Usual Residence of Decedent				Aug. 16	,1924 of (	Columbia
	how			y, Town or Lo	cation				10d. Inside City Limits
	e Ma Sa-f s	cg	MD Anne Arundel Ar	mold					1 □Yes 2 No
	iges 1 and 2 should be filled within 72 hours after death with the Maryland at of Health and Mental Hygiene. And Health and Mental Hygiene. I fee if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Nu <i>m</i> ber 507 Bay Dale Court		10f. Zip Code 2101	12	1	Og. Citizen of What Cou USA	intry?
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36	or It	by Fu	1 Never Married 2 Married 1 Meyer 2 No		l □Yes 21√2 No		o rilicari, ctc.)	Black, White  Specify: W	nite
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212	r thai	E O	Elementary/Secondary (0-12) College (1-4or 5+)	_	anical Er	· _		Manufactur	ing
٦	othe othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, M	Maiden Surname)	
<u> a</u>	should be ind Mental marked o	To	Thomas Dowell McAvoy, Sr.			Elizab	eth Parke	er	
lar)	and l	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number	, City or Town, State, Z	ip Code)
≥ .	and m 27 her tr		Shirley S. McAvoy/ wife			e Court A	rnold, M	21012	
ore.	Fages 1 nent of F ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	lace of Disposemetery, cren	sition (Name of natory or other place	ce) Jan	13	20c. Location - City or T	
altimore, Maryland 21215-0036	t. Partmen		4 □ Donation 5 □ Other (Specify)		matory,	11VC-1	2009	Baltimore,	MD
Ba	permit. Pages 1 and 2 Department of Health Important: If item 27 it any Injury or other tra		21. Signature of Funeral Service Licensee	∣Ba		Sons, P.		na Park Fur na Park, M	
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	/Medical Examiner		Due to (or as a conseq	Ance of):	ah lom	ina O a	14-	200 4	
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or/as a conseq	LCX C	waum	unex a	IDLC C	recaryon	
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39	ing pl	Med	IF FEMALE:						
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o }	by the a	Physician/Me	1 ☐Yes 2 ☐No 4 ☐ Pregnant at time of c		Other (specify) _			Month	Day Year
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Hec	certificate has birector, page 2 s	g E					24a. Was ar autopsy perforn	v prior to co	opsy findings available ompletion of cause of
Vital	ifficati		25. Was case referred to medical				1 □Yes 2	¹ Maria 1 □ Yes	2 □No
	r this certificaral director, programment	o Be	examiner?	ER/Outpatien	Oth		th (Check only one		
Ö	er this eral dii	n:T	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injur Worl	4 Li Nursing H	ome 5 ☐ Heside 28d. Describe ho	nce 6 Other (Special winjury occurred	fy)
o i	ath. r: After ne funera	atio	1	Injury		k?  Yes 2 □No			
DIVISION OF	ter death	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specif	me, farm, stre	et, factory, office		28f. Location (Str City or Town	reet and Number or Run	al Route Number,
ב כ	ours af		20g Cartifier 4 Death in Physician 7 11						
1	within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my kno 2 Medical Examiner: On the basis of examina and manner stated.	wledge, death tion and/or in\	occurred at the tile estigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due t	stated. o the cause(s)
Š	vithi 70 th	ğ	29b. Signature and title of certifier		29c. Licens	se number	29	9d. Date signed (Month,	Day, Year)
	X	1	MI) male		D45	3019		JAN 10	2009
,	(9xx)	M	30. Name and address of person who completed cause of death (Item	23a) (Type, F	Print)	Drin	Aunt	10000 00 441	1 2 4 6 4
	Va		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ING	UICHC	rawy	17/1/1/	POLIS ML	12140
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signa	h has	Mad				

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical State

Registrar

(Check only one)

29b. Signature and title of cartifier

ROBERT KAUFMANN, MD 31. Date filed (Month, Day, Year) JAN 2 0 2009



2 Medical Examiner: On the basis of examination and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

9th ST., FREDERICK,

d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MD

29d. Date signed (Mgnth, Day, Year)

21701

	4	For	Please	e Type or Pri State of M		d / De	partment of H	lealth and				02003		
	]	State Registrar	(F) 40 40			<i>C</i>	ertificate of	Death	1000	Reg. No.	009			
Physician /Medica		1. Decedent's Name  Lillian	1	Belva		iller			2. Date of De Month Januar	y 18	Year 2009	3. Time of Death <b>3:35 A.</b> M		
Examiner Funeral Director		4a. Facility Name (If not institution, give street and number)  Northampton Manor  5. Social Security Number 6. Sex 7. Ag  217-10-0874 1 □ M 2   F				4b. City, Town, or Location of Death  Frederick  e (In yrs. last birthday)  Nonths Days Hours Min.  Apri					4c. County of Death  Frederick  Birth Day, Yeer) 19, 1919  4c. County of Death  Frederick  9. Birthplace (State or Foreign Country)  Maryland			
Maryland f show	İ	Usual Residence of D 10a. State Maryland	10b. County	ERICK		ty, Town or						10d. Inside City Limits 1 ■Yes 2 □ No		
3a or 28a-f st		10e. Street and Number  West Moser Road				10f. Zip Code 21788					of What Cou	intry?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I've Ivadical Examinar must be notified at once.	5	11. Marital Status 1 Never Marrie 3 Widowed 4	_	12. Was Decedent Armed Forces' 1	•	.S. 1	3. Was Decedent of Hif Yes, specify Cubin	dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Ne erto Rican, etc.)	No-  14. Race - American Indian, Black, White, etc.  Specify: white				
tal Hygiene tal Hygiene do the Hygiene do ther than "natura event, the Mydical E	- Indiana	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5			5+)	(G lif	ecedent's Usual Occupive kind of work done ie. DO NOT use retire	during most of w	rorking	16b. Kind of Business/Industry				
tygier ther th	5	11	Times Asiminity 1 -			Home	emaker	40 44-46-4-1	/Fine & # # # # # # # # # # # # # # # # # #	Maida - Our	USA			
d be fi		17. Father's Name (F John	Lee Sm						ame (First, Middle Edith R		,			
and 2 should ealth and Men n 27 Is marke ner traumatic	-	19a. Informant's Nar Richard M	me/Relationship		1		ailing Address (Street	and Number or	Rural Route Numb	ber, City or To	wn, State, Z	ip Code) . <b>788</b>		
Pages 1 ar		20a. Method of Dispo 1 ☐ Burial 2 🛣 4 ☐ Donarjon 5	Cremation 3	Removal from State			sposition (Name of crematory or other place Crematory		Date 2-2009		on - City or T	own, State		
permit. Departn Importa any Inju		21. Signature of Fun		7	ali	ine	22. Name and Addres	•	Stauffer Pike, Fr					
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Interval Between Onset end Death mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a/consequence of):  c. Due to (or as a consequence of):  d.												
nat the death certificate be d by the attending physici letached for use as the bu	ly sicial and	IF FEMALE: 23b. Was decedent y in the past 12 m 1 ☐ Yes 2 M 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	al death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy		23d.	Date of deli Month	very Day Year		
w requires that been signed to should be detailed.	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									contribute to the cause of death?  o 3 Probably 4 Unknown			
sIclan: The law required to certificate has been s rector, page 2 should		25. Was case referre	ed to medical					Oc. Diago of D		ppsy ormed? 2 <b>X</b> No	prior to c death?	topsy findings available ompletion of cause <i>o</i> f		
Physician this certail direct	examiner?									Other (Spec	sifv)			
Ital or Attending Physics after death.  Tal Director: After this led in by the funeral director.		27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 1 Yes 2 No  28d. De 28d. D								28d. Describe how injury occurred				
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun									City or To	ation (Street and Number or Rural Route Number, or Town, State)				
the Hospithin 24 hours of the Funer or the F	200	(Check only one)	2 Medical Ex	Physician: To the best caminer: On the basis and manner s	of examina tated.	ation and/o	or investigation, in my	opinion, death oc	courred at the time	, date and pla	ce, and due	to the cause(s)		
To Cor		29b. Signature and ti	itle of certifier	2/	-,		29c. Licens	943091		29d. Date si	19 - 0	n, Day, Year)		
(4)		30. Name and addre	ess of person when Zar	no completed cause of	death (Iter	m 23a) (Ty 81/	pe, Print) Toli	Loure	Aue,	Fred	enle,	1, Day, Year) 19 19 24 70/		
State Registra		51. Date filed (MONT	JAN 2	1 2009 22. Hegis	self a signa	A.	parker							
HMH 17 Rev 1/200	1			4			-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANE ANN MCHALE 17 JAN. 2009 9:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 18340 CATTAIL ROAD POOLESVILLE MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours 91 27 015-07-3816 JAN 1917 **Director** MA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County other than "natural", or Items 23a or 28a-f show rent, the Medical Exeminar must be netitied at 1 ☐ Yes 2 YNo Director MD MONTGOMERY POOLESVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 18340 CATTAIL ROAD 20837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 ☑No altimore, Maryland 21215-0036 <u></u> Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANTONY WOJCIK ANNA CEBULA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shing Department of Health and Important: If item 27 is many injury or other traumonce. 19a. Informant's Name/Relationship (Type. Print) PAMELA VINCE / DAUGHTER 18340 CATTAIL RD., POOLESVILLE, MD 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1/21/09 STAUFFER CREMATORY FREDERICK, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Dementia VASCULAR magrassive disease or condition resulting in death) /Medical Examiner Carlor Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Vascular the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical attending p as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Distrolar 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy feduced aran INTAKE Alexaded with Jerrerely 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No DONENTIA 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) Injury 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide thin 24 hours aft the Funeral Di impletely filled in Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

E. LESSIN, UND. Swife 207 31. Date filed (Month, Day, Year) 32. Registrar's Signature

PitysiciA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(313 Dolley MADION BLUD, MCLEPN, VA 22101 barto

29c. License number

0101023985

State of Maryland / Department of Health and Mental Hygiene 009 02885 For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Veal **Physician** ARTHUR MARDIS 10:00 P M JANUARY 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Health Care - Layhill Center Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 28 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1923 Months Days Hours 1 M 2 □ F 524-16-5633 85 Director Illinois Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rai', or itams 23a or 28a-f show Examiner must be nutilised at 1 Yes 2 No Olney Director Md. Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 17247 Sandy Knoll Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give WWT 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: White Specify: WWII þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic svent, the Medical Elementary/Secondary (0-12) College (1-4or 5+) other than **1**2 Clergyman Clergy 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Mardis Margaret Tuttle Chester John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trai once. Linda Keiser Mardis / Wife 17247 Sandy Knoll Drive, Olney, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 1/21/09 Alexandria, Va. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MALIGNANT MELANOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9□ Unknown nas been signed by t n 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy performed page 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 5 Pending 1 TYes 2 No investigation 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur title of certifier D0064208 20 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20737 4409 EastWest Highway, Riverdale, Md. Saadia Husain, M.D. 31. Date filed (Month 32 Registrar's Signature backs State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Medley 19 18:32 Elizabeth Pepe 2009 Sanuari /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore bhas HOPKINS If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) June 7, 19 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 X F 79 187-24-1454 1929 Uniontown, PA Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural', or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Riverdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with the Hygiene. 20737 USA 5803 67th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Government 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F Mary Willey Crestino Pepe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Darlene Giaffes / Daughter 11021 Suffolk Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 1/24/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 4739 Baltimore Avenue umot Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Preumonia Mulhiobular Wark disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Smau (e) ling cancer
Eve to (or as a nonsequence of): 5 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran Due to (or as a consequence of): Box 68760, attending physician be Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division or Vital Records, P.O. detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 No 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After , Year) 1 Natural 5 Pending investigation spital or Attendli nours after death. neral Director: A / filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) frontaum, MEDICAL DUCTOR RES-000 January, 19,2009

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenbaum

31. Date filed (Month, Day, Year)

JAN 2 1 2009

Hospital, 400 North Wife Street, Baltimore, Mary land 21287

•	•		
State of Maryland / Department of Health and Mental	Hygiene ? n C	19 0	28
Certificate of Death	Do- No C U C		20

1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12 20°0°9 Month **Physician** 10:04 AM January McKellar Raymond /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/16/1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F **Funeral** Days 58 Michigan 364-54-9035 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f shov ral", or items 23a or 28a-f shore Examinar must be notified at 1 □Yes 2 XNo Director Airville PA York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17302 U.S.A. 7227 Woodbine Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No "natural", or Specify Specify: White by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 Is marked other than "nature traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equip Operato Laborer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Ann Miller Lloyd Allen McKellar ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 Is any Injury or other trau once. 7227 Woodbine Rd. Airville, PA Cinda McKellar 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Chester, PA A. Ferris & Co. 1/15/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001 21. Signature of Funeral Service Lice 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute bowel perforation /Medical Due to (or as a consequence of): Examiner Erosion of intra-abdominal desmoid tumor Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □No 5 Other (specify). 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acute renal failure has been signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate 2 XNo 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 12, 2009 enko 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sergy N 31. Date filed (Month, Day, Year) esterenteo

State Registrar DHMH 17 Rev 1/2001 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02888 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 12m **Physician** January Viola R. McAvoy 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Lion's Center Cumber land **Allegany** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F 86 27,1922 228-26-9099 Petersburg, WV Director Jan. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show Is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Experience must be rettlined at 1 ☐ Yes 2 No Director WV **Mineral Burlington** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Rt. 1, Box 68 Funeral **26710**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify Specify: 3 ☐ Widowed 4 🙀 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housekeeping Dept. Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental John Edward Thorn Eula Ethel Stewart or other traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Importent: If Item 27 Is
any Injury or other trau Rt. 1, Box 68-A Dianne Biser/Daughter Burlington, WV 26710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 25 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Antioch, WV Thrush Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License Smith Funeral Home Paring 0 Rt. 2, Box 1-A Burlington, WV 26710 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coro nou **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 🗽 1 Yes 1 🗆 Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pist hours after death.
e Funeral Director: After the letely filled in by the funera After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) year) Skinu Kent 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

3

			For State Registrar	State of M	aryland	d / Depa	artment of H	lealth and Death	l Mental Hy	giene Reg. No.		02889	
			Decedent's Name (First, Middle, La	ist)					2. Date of De			3. Time of Death	
	Physici /Medio		Mariorio Mo	Toon		Ja						9 1919 pm	
	Examin		Marjorie Mc 4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of De			22 2009 1919 4c. County of Death		
			Prince Georges				Cheve					Georges	
	Funeral			Sex 7.Ag 1 ☐ M 2 ☐ <b>X</b> F	је (In yrs. la 71	ist birthday) Yrs.	If Under 1 Year Months Days	Hours Mi	n. (Month. Da	av. Year)	Co	thplace (State or Foreign ountry)	
	Director		248-58-5360 Usual Residence of Decedent						2/11	193	7 S.	C.	
	ylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	BB-f-	cto	MD Prince	Georges	Land	dover						¹☆Yes 2□No	
	ith th	Director	10e. Street and Number				10f. Zip Code				zen of What Co	ountry?	
	s 23s	era	1700 Bright	seat Rd		121	20785 Was Decedent of H	ianasia Origina	/Coopin Voc or N		3 . A . 14. Race - Ame	rican Indian	
	fter d	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces?			Yes, specify Cuba	in, Mexican, Pu	erto Rican, etc.)		Black, Whit	te, etc.	
9	al', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	I⊡Yes 2⊡xiNo	Specify:			Specify: bla	ack	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow he Mudical Exervither mast be mulified at	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Deced	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of w	rorking		nd of Business		
7	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)								
7	Hygie ther t		1 0 17. Father's Name (First, Middle, Last	·)		n	<u>omemake</u>		ame (First, Middle		vate		
Maryland	d be ental ked o	To Be	Chester Rog						McCutc		<i>Damamo</i> ,		
ary	shou nd M mar	۲	19a. Informant's Name/Relationship (			19b. Mailin	g Address (Street	and Number or i	Rural Route Numb	er, City o	r Town, State,	Zip Code)	
Σ	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28s-1 show or other traumatic event, the Marical Examinations is neitilised at		Wendy Sorre	1		1700	Bright	seat R	d #101	Land	lover,	Md 20785	
ore	of He of He if Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo	sition (Name of		Date	20c. Lo	cation - City or		
Ĕ	Pag ment tant: l		4 □ Donation 5 □ Other (Special		Ft	. Li	ncoln C	emeter	Y 30/09	Bla	adensb		
Baltimore,	permit. Pages: Department of H Important: If Its eny injury or ot		21. Signature of Funeral Service Lice	nsee	,	22	. Name and Addres	ss of Facility H	odges a	and 1	Edwards		
	403 e d		ANUL CU	way	d the death	39	10 Silv	er Hil	l RD.Su	uitla	and, MD		
п			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. After 13 Clenatical Candidation (or as a consequence of):										
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	ocuted nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):										
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8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dlcal		d									
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Вох	atten after of for u	Physician/Med	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy							2	23d. Date of delivery  Month Day Year		
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ğ	w require been sig should b	pel		mal Dis					1 🗆	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
မင္ပ	law ra as be	ple	Parkinsons Disease							Was an autopsy findings available prior to completion of cause			
Division of Vital Records,	The	Completed								2 No	death? 1 ☐ Yes		
Zi Si	icien: Th certificete rector, peg	Be	25. Was case referred to medical examiner?	Hospital:		,	0.15		eath (Check only	one)			
ō	Attending Physicien: r death. sctor: After this certifice by the funeral director, I	. To	1 Yes 2 No  27. Manner of Death	28a. Date of Inju	T-	R/Outpatien 28b. Time of		4 🗀 Nuising	Home 5 ☐ Resi			cify)	
o	ding th: : After	tlon	1-☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	Injury	28c. Injun Worl	k? Yes 2 □ No	200. Doscribo	now injury	y occurred		
N S	Atter r dea sctor by the	Ifica	3 Suicide 6 Could not b	28e. Place of Inj	ury - At hom	ne, farm, stre	eet, factory, office					ural Route Number,	
Ö	s after el Dirse ed in by	Certification:	4 [ Nothicide	building, et	c. (Specify)				City or To	wn, State,	,		
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funarel Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1. Certifying Pt (Check only one) 1. Certifying Pt 2. Medical Example (Check only one)	nysicien: To the best miner: On the basis o	f examination	rtedge, death on and/or inv	occurred at the ting restigation, in my of	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)	
and manner stated.  Section 19										e signed (Monti	h, Day, Year)		
	,- > - 0		Mr. Ola	allevion	Uhr	9	Do	1850	2 .	TALL	2AN4 22	2009	
			30. Name and address of person who	completed cause of c	death (Item 2	23a) (Type,	Do Bury le		-4.4	a 1			
			Paul A. DEVOS	E MIDIEZ	34	seens	bure, le	el Hya	ITSVILLE	· mi	1207	81	
	Sta Registr		31. Date filed (Month Pay 2200	9 Registr	ar's Signatu	far	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician January 20 2009 2:30 a.M Marie Caroline Newcomb /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cambridge Dorchester Mallard Bay Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F June 4, Maryland 88 1920 Director 220-03-4858 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Dorchester Cambridge 1 ☐ Yes 2 No MD Examiner must be notified Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 12 Jenkins Creek Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No white Specify: þ 3X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 10 Health and Mental Hyginem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental I Clara Fischer Joel Cooke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21613 1308 Colonial Aveue, Cambridge, MD Joel M. Newcomb son 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 : 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 1/24/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic 3 months Physician Cervical cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 XNo director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Hospital or Attending Physician:

24 hours a within 2 the

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 120/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ohnson

100 Bramble

Cambridge, MD

and manner stated.

			For State Registrar	State of Marylan		artment of F <i>rtificate of</i>			ene 9. No. 2 N N O	00001	
	Physici	an	1. Decedent's Name (First, Middle, Last)		0.14			2. Date of Death	28°, 200°9°	3. Time of Death	
-0-3-24	/Medic Examir	cal	Ernest Rot  4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. County of Death	1:00 pm	
	LAMIIII	IGI	Citizens Nursing			Frede	rick		Freder	ick	
ı	Funeral Director		072-09-0445	7. Age (In yrs. I 101		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Mov 11,	1907 Aus	nplace (State or Foreign untry) Stria	
21215-0036	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  Maryland  Trederic		, Town or Lo Freder					10d. Inside City Limits 1 X Yes 2 □ No	
	th with the 23a or 28a	Funeral Director	10e. Street and Number 608 Biggs Avenue		10f. Zip Code			100	g. Citizen of What Cou	untry?	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 🌣 Widowed 4 □ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🛛 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh		
	filed within 72 ho Hygiene. other than "natu ent, the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Aurant Ow	during most of work d)	ing 16	6b. Kind of Business/li $Food/Beve$	•	
Maryland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, I'm M	To Be C	17. Father's Name (First, Middle, Last) Wilhelm	Nasher			18. Mother's Name Fannie	e (First, Middle, Ma	aiden Surname) Weisn	er	
	1 and 2 should Health and Mer em 27 is marke sther traumatic		19a. Informant's Name/Relationship (Type Rosalind Nasher,	Daughter	608	Biggs Av	enue, Fre		City or Town, State, Z Maryland 2	. ,	
Baltimore,	permit. Pages 1 a Department of Her Important: if item any injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify),			sition (Name of matory or other place n Mem Gar			Cc. Location - City or T Frederick,		
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- Can	Physician /Medical	25	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	cations that caused the death le cause on each line.  Due to (or as a consign	1 Roll	er the mode of dyli	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	ifficate be executed g physician and ss the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Un M	arter	y dise	rse			
O. Box	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							very Day Year	
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Division o	pital or Attending Phous after death. eral Director: After the	Certification:	27. Manper of Death  1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At ho building, etc. (Specify		28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)					
۵	pital Durs eral filled	ledical Cer	29a. Certifier (Check only 2 Medical Examir	sician: To the best of my knowner: On the basis of examinat	wledge, deat	h occurred at the ti	me, date and place,	and due to the cau	use(s) and manner as	stated.	
	To the Hos within 24 ha To the Fun completely	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	290	d. Date signed (Month	, Day, Year)	
			30. Name and address of person who co	0 -	23a) (Type,	Print) WEST	NINTH S	T; FREI	January 2 DERLICK, N	ND 21701	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat					1		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DORIS Μ. ODUM 2009 January 18 11:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner OLNEY

If Under 1 Year | If Under 24 Hrs.

Days | Hours | Min. MONTGOMERY 18213 HILLCREST AVENUE 8. Date of Birth (Month, Day, Year) Feb. 7 191 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months 1 □ M 2 1 F 577-01-9943 90 Director 1918 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a State 10d. Inside City Limits 10h. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Md. Olney Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18213 Hillcrest Avenue 20832 United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 😿 No If Yes, Give Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be family and Mental F Thomas Pancratius Mayhew Elware Althoff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If item 27 Is
any Injury or other trau Lisbeth O. Rodriguez/Daughter P. O. Box 742, Arecibo, Puerto Rico 00613 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 1/22/09 Silver Spring, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE DAYS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the as nding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth atten 3 □Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Il or Attending Patter death. After t Certification: 1 🔁 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral E 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hysicres 0055694 January 19, 2009

DHMH 17 Rev 1/2001

Registrar

Box 68760.

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Records.

Division or Vital

4000 Olney-Laytonsville Road, Olney, Md.

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Alok Mathur, M.D.

JAN 2

31. Date filed (Month, Day, Year)

			For State	State of	Marylan		rtment o			Mental Hyg	21	009	0.2	893	
			Registrar  1. Decedent's Name (First, Middle, Last	Cer	illicate	Dea	1111	2. Date of Dea							
	Physicia	an			Month	Day	Year								
4	/Medic				ster		4h City Tou		tion of Dooth	January	-	2009	6:28	P M	
	Examin								tion of Death			ty of Death			
			Frederick Memoria 5. Social Security Number 6. Se		tal . Age (In yrs.	last hirthdou		deric	k nder 24 Hrs.	8. Date of Birtl		rederi	LCk place (State	as Familian	
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	land ow		10a. State 10b. County	<del></del>	10c. Cit	y, Town or Lo	cation						10d. Inside (	City Limits	
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	the 1	Director	Maryland Frederi  10e. Street and Number	.CK		rit.	Airy 10f. Zip Co	de			10g. Citizen of	Mhat Cou	ntry?		
	with a or			•			2.1	771			TT. J.	1 C.			
	is 23	Funeral	12897 Colonial Dr	12. Was Deced	ent Ever in U	S 13 V		771 of Hispani	ic Origin? (Sr	necify Yes or No-		ed St			
	iter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Ford	es?	.   10.1	f Yes, specify	Cuban, Me	exican, Puerto	pecify Yes or No- Rican, etc.)	BI	ack, White,	etc.		
38	rs af	þ	3 Widowed 4 Divorced	If Yes, Give	-	1	∐Yes 2 <b></b> K	No Spe	ecify:		Spec	ify: Wh	nite		
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0	filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)	<u> </u>				18. 1	Mother's Nam	e (First, Middle,	Maiden Surna	ıme)		-	
an	d be ental ked c	To B	Gabriel Grasser						Rortho	August	tina T	'aveau	1		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show umatic event, the Modical Examinat must be notified at	ř	19a. Informant's Name/Relationship (T)	(pe. Print)		19b. Mailin	a Address (S			ral Route Numbe					
≅	d 2 s Ith ar 17 is trau		Dana Oster / Son	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						Mt. Airy	•				
φ	1 an Heal em 2		20a. Method of Disposition		20b. F					Date All	20c. Location				
و	nt of int of int of int of int of int of int of int of int of or or or or or or or or or or or or or		1 ☐ Burial 2 ☑ Cremation 3 ☐ F		ate	Place of Disponentery, cren			Jan	uary		,			
ij	t. Partment		4 □ Donation 5 □ Other (Specify)		Sta	uffer	Cremat	ory	19,	2009	Freder	ick,	Maryla	and	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lainy or other traumatic event, It a Noticel Examiner must be notified any once.		21. Si ature o uneral Service Licens	6		8	E. Rid	gevil	le Blv	auffer F	uneral Airy, M	Home laryla	s, P.A and 21	771	
		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approxima Interval Be Onset and	ite etween	
may.	Physician		Immediate Cause (Final disease or conditiona Coronary Artery Disease										Years		
-	/Medical		resulting in death)	Due to (o	r as a conseq	uence of):									
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	D #	Examiner	Sequentially list conditions, if any, leading to immediate the conditions of the con												
	ecute ind trans	am	Cause (Disease or injury that initiated events c. The providing in death) Last  Due to (or as a consequence of):												
Ö,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (o	r as a conseq	uence of):									
8760,	ate b hysic he bi	dical		d											
36	ng p		IF FEMALE:												
Вох	eath certifi attending p for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outco	ome of pregna rth 2 🗆 Feta		Ectopic pred	nancv				ate of deliv	,		
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ta	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medical					26	Place of Deet	1 □Yes_ th (Check only or	2 X No	1 ☐ Yes	2 X No		
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ou	dIng Phy h. After thi funeral o	ţ	1 Natural 5 Pending 2 Accident investigation	(Month	Date of Injury (Month, Day: Year)    Date of Injury   28b. Time of Work?   28c. Injury at Work?   1 □ Yes 2 □ No					250. 2505 nov injury coounted					
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Division of Vital Records, P.O.	or A after Dire	Certification;	4 ☐ Homicide determined	building	g, etc. (Specif	ome, farm, stre	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Tow				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	spita ours ieral filled		29a. Certifier 1 X Certifying Phy	sician: To the h	est of my kno	wledge, death	occurred at	he time de	ate and place	and due to the	cause(s) and	manner as	stated.		
	24 h	edical	(Check only 2 Medical Exam		sis of examina									(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p	Med	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)				
	7		Lalila		7	Carr	DC	05942	23		Januar	ry 19	, 2009		
	121		30. Name and address of person who c	ompleted cause	of death (Iten	n 23a) (Type,	Print)						21029		
	()		Ndidi Feinberg, M	1.D. 66	30 Dav	break	Circle	, Sui	te Al5	0-236	Clarksv	ille.			
	Sta	te	31. Date filed (Month, Day, Year) JAN 2 1 200	32. Re	gistrar's Signa		ake								
	Registr	ar	JAN 2 1 200	17 /6	seed ,	10. 1400	CLICA								

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tony Pasqual 14, 2009 January 1:04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 5, 9. Birthplace (State or Foreign Country) West Virginia Months Days Hours 1**▼** M 2 □ F 233-34-2187 86 Feb. 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4514 Bennion Road 20906 by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building & Maintenance Mechanic United Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Geovania Angello Pasquale ည Mary Pasquale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy K. Pasqual/Wife 4514 Bennion Road, Wheaton, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 19, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 4 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock 4 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia 8 days Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2☐No g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Gastric Lymphoma, Chronic Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 2 **12** No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

burial-tran P.O. Box 68760 attending physician for use as the buria certificate be ed by the a detached for signed by to be a detach Division of Vital Records, certificate has page 2 s or Attending Physician: this funeral After death. filled in by the

Physician

**Funeral** 

Director

show

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the Maryland

with 1

death

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
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permit. Pages the Department of Humbortant: If ite any injury or ot

**Physician** 

Examiner

/Medical

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Physician/Medical

Completed

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Certification: To

Medical

Baltimore, Maryland 21215-0036

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely

Shailesh Sheth, MD State

2 Accident

4 Homicide

(Check only one)

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐Yes 2 ☐ No

January 14, 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 14,2009 **Physician** ERNEST ELLWOOD PORTER 12:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPICE CENTER OF OUEEN ANNE'S QUEEN ANNE'S CENTREVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months 1 X M 2 □ F Director 217-36-0917 88 MARYLAND NOV.21,1920 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits ; or items 23a or 28a-f shaminer must be notified 1 ☐ Yes 2 No Director MD QUEEN ANNE'S CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21617 130 PORTER FARM LANE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. traumatic event, the Medical Examiner 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify. WHITE Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 -0-FARMER FARMING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM EDWARD PORTER EMMA ROZENA LANE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and 130 PORTER FARM LANE, CENTREVILLE, MD 21617 HILDA MAE PORTER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY JAN.17,2009 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical months **Examiner** Sequentially list conditions, to for as a convenuence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 1 ☐ Yes No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

rowken

JAN 15 2000

29d. Date signed (Month, Day, Year)

lone, Easton, No

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Audrey Thelma Pedone 2009 2220 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Carrol1 Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea June 24 Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 M 2 TF Min. 83 Director 213-20**-**9454 1925 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 505 High Acre Drive Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygid Important: If item 27 is marked other any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Owen Welsh ဥ Minna Koehler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Pedone/daughter Topanga, CA 90290 20666 Cheney Drive Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 1/16/2009 Hampstead, MD 21. Signature of Funeral Service Lidensee Prints of the ration of the Prints of the Pr 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical or as a consequence of): Examiner tA1/4 Ecquentially list curuntums, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 □ Yes 2 □ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifie

WIL

State Registrar 30. Name and address of

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) Date of Death Month Year WILLIAM DONALD PLEASANTS JANUARY 20 2009 6:20 Α 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPTTAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 238-36-5211 1 X M 2 □ F 81 Sept. 18,1927 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Marvland Frederick Frederick 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11530-B Liberty Road 21701 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 👿 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Excavating Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Marvin Pleasants Arete 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Pleasants, Jr./Son 15408 Conrad Spring Road, Boyds, MD 20841 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Mem. Gard 1/25/2009 Frederick, MD ure of Funeral Service L 22. Name and Address of Facility Stauffer FuneralHome 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final PNEUMONJA BILATERAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CONGESTIVE HEART FAILUKE Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSIUN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No autonsy 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

ims 23a or 28a-f shi r vust be notified a

permit. Pages 1 and 2 should be filed within 72 hours after do Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Exprinter and any Injury or other traumatic event, the Medical Exprinter.

3altimore, Maryland 21215-0036

Director

Funeral

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Completed

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with the Maryland

death 1

/Medical

Examiner burial-tran the attending physician hed for use as the buria Physician/Medical ģ þ Completed page 2 s director, Be မ

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After

To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the ft

Certification:

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1∐ Yes 2⊠No

27. Manner of Death 1 Natural

5 Pending 2 Accident investigation

6 Could not be determined 3 Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Proceduring Physician: To the dest of thy knowledge, death occurred at the time, date and place, and due to the datasets, and the time, date and place, and due to the cause(s) and manner stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number D0063498 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, MD 21701

State Registrar

CAKHVINDER 31. Date filed (Month, Day, Year) JAN

WADHWA 32. Registrar's Signature

Darka

		For State Registrar			Certificate of		Re	g. No. 200	02898			
Physic	ian	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death			
/Medi	cal	Thomas A.  4a. Facility Name (If not institution, gi	Poston		4b. City, Town, o	r Location of Dea	January	4c. County of Dea	1.00 A			
Exami	ner	Montevue Hon	·		Freder			Frederic				
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last bir				9. Bir	thplace (State or Foreign			
Director		235-68-3813	1□ M 2ŽŠF 64	·	Yrs. Months Days	riouis Will	Nov. 17,	1944 Wes	st Virginia			
pu 🔉		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Location				10d. Inside City Limits			
f sho	5	Maryland Freder		**	lerick				1 <b>x</b> Yes 2 □ No			
the h	rect	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?				
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	355 Montevue	Lane		2170	2		USA				
deat	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	lispanic Origin? (	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.				
or it	by Fu	1 Never Married 2 Married	1 ☐Yes 2 ☐No	D	1 □Yes 2 X No	Specify:	. ,	Specify: white				
bours tural"	d be	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:	16a	Decedent's Usual Occup	ation		6b. Kind of Business/Industry				
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d with giene	E O	Elementary/Secondary (0-12)	College (1-4or 5+		Lab Technici	an		ncartn				
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s should be filed withing and Mental Hygiene. Is marked other than aumatic event, It all	2	Noah Poston					hel Griffi					
12 shand hand 7 Is m		19a. Informant's Name/Relationship  John Poston	(Type. Print) <b>Brother</b>		. Mailing Address (Street							
1 and 1 and Healt em 2		20a. Method of Disposition	DIOCHCI		I 134 Anglebe  f Disposition (Name of ry, crematory or other place)			rmont, Maryland 217				
Pages 1 and 2 s ment of Health ar ant: If item 27 Is ury or other trau		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec.			ry, crematory or other place <b>Fer Cremator</b>			•	, Maryland			
permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Lice		2.	22. Name and Addre		Stauffer F					
and in the second		Sharow Ea	mille. E.	leno	1621 Oposs							
	/	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused to	the death. Do	not enter the mode of dyir	ng, such as cardi	ac or respiratory arre	est,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	_ (	Jor Nie	.1	1hm a			Onset and Death			
/Medical		resulting in death)	Due to (or as a									
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ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	01):							
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ath cerattendii	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth		a 3 ☐ Ectopic pregnanc	:y		23d. Date of de Month	elivery Day Year			
the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify) _			Nionin	Day Teal			
rthat the		Part II. Other significant conditions	contributing to death bu	t not resulting in	n the underlying cause giv	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?			
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ng Phy kfter this	ü	27. Manper of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day,		Time of 28c. Injui njury Wor	ry at k?	28d. Describe hov		-107/16			
Attending ar death. ector: Afte by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	ha			Yes 2 □ No	001 11 (0)					
or At after d Direct in by	Certification:	4 ☐ Homicide determined		ry - At home, ta . <i>(Specify)</i>	rm, street, factory, office		City or Town,	eet and Number or F , State)	lural Houte Number,			
spital ours a peral I		29a. Certifier 1 Certifying F	Physician: To the best o	f my knowledge	e, death occurred at the ti	me, date and pla	ice, and due to the ca	ause(s) and manner a	as stated.			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination ar	nd/or investigation, in my o	opinion, death oc	curred at the time, da	ate and place, and du	e to the cause(s)			
To th Withir To th comp	Me	29b. Signature and title of certifier	1/11		29c. Licens	e number		d. Date signed (Mon				
0		> Sheel 1	610		04	1371	J	anuary 19	, 2009			
(3)		30. Name and address of person who				,						
	1	Michael Costel 31. Date filed (Month, Day, Year)	00 00 1	1 01 1 4	Opossumtown	Pike,	Frederick,	Maryland	21702			
St Regist	ate trar	JAN 21	2009 1 Section	Man A	parke							
9,10		79 6 6 7 4	1	*	7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

09-00381 Mary Ricca Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ary Ricca	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  1- For State Registrar  1- For State Registrar	9
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last)  Mary Haley Ricca  2. Date of Death Month Day Year January 13, 2009  3. Time of Death 1143 hrs	
	4a. Facility Name (if not institution, give street and number)  Suburban Hospital  4b. City, Town, or Location of Death  Bethesda  4c. County of Death  Montgomery	
Funeral Director	5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Months Days Hours Min. 1. Months Days Hours Min. 2x F 80 Yrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Country) D. C.	gn
w any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  1 Yes 2 XN	
the Maryland or 28a-f show tified at once.  Director	Maryland Montgomery North Bethesda 1 Ves 2 x North Street and Number 10f. Zip Code 10g. Citizen of What Country? USA	
r death with the Maryland or items 23a or 28a-f sho must be notified at once Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 2 X No  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White	
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21215-0036 uld be filed within 72 hour Mental Hygiene marked other than "natu r event, the Medical Exan To Be Completed		
MD 212 d 2 should be tth and Ment n 27 is mark anmartic even To E	19a. Informant's Name/Relationship (Type, Print)  John Peter Ricca/Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  15535 Edwards Ferry Road, Poolesville, MD 20837	
Baltimore, MD 2 permit Pages I and 2 shou Department of Health and N important: If iron 27 is reinjury or other tranmatic	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory  20b. Place of Disposition (Name of cemetery, crematory or other place)  Metropolitan Crematory  20c. Location - City or Town, State  Alexandria, Virgini	Ĺa
Balt permit Depart Import injury	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 209  23a. Par I. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interview	
Physician /Medical kaminer	Failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Between Onset an Death  Between Onset an Death  Due to (or as a consequence of):	
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s, P.O. Baires that the de signed by the detached f	CHRONIC ALCOHOL ABUSE WITH CIRRHOSIS OF THE LIVER 1 Yes 2 No 3 Probably 4 Unknown	
Division of Vital Records, tal or Attending Physician: The law requires its after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed	24a. Was an autopsy findings available prior to completion of cause or death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	
ital Re- nician: The s certificate irector, page	25. Was case referred to medical examiner? Hospital: 4 Incation 2 of EP/Outgation 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:	
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Division o  Division o  24 hours after death. Finarral Director: Aftered in by the functed filled in by the functed filled in by the functed filled in by the functed filled in by the functed filled in by the functed filled in by the functed filled filled in by the functed filled in by the functed fille	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, Ci or Town, State)	ity
To the Host within 24 hc To the Firm completely f	743 Leffiller	
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E.  January 15, 2009	
	30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra		

		•	For State Registrar		State of Ma	aryland	•	rtment of rtificate of	Death		_	2009	02900
	Physicia		1. Decedent's Name (First,	Middle, La						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Arnold		Rauss			01. 7		Januar	y 13,	, 2009	9:30 p M
	Examin	er	4a. Facility Name (If not ins					_	or Location of Deal	in	4c.	County of Death	
	Funeral		Collingswoo  5. Social Security Number	6. S	Sex 7. Ag	nab. e (In yrs. las	at birthday)	If Under 1 Year		8. Date of Bir	th Vegr)	Montgor 9. Birth Cou	place (State or Foreign
	Director		083-20-1782	1	<b>⊠</b> M 2□ F	82	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Jan. 31	, 19	26 New	York
	and	}	Usual Residence of Deceder 10a. State 10b. C			10c. City,	Town or Lo	cation					10d. Inside City Limits
	Maryl -f sho	ţō	Maryland	Mont	gomery	s	ilver	Spring					1 □Yes 24DXNo
	or 28a	Director	10e. Street and Number		90			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	th with	ralD	3330 N. Le	isure	World Bl	/d., #			20906			USA	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Evacinar must be not find a once.	by Fu	11. Marital Status  1 □ Never Married 2X 3 □ Widowed 4 □ Div		12. Was Decedent Armed Forces? 1 □Yes 2 X If Yes, Give Year or Dates:			Was Decedent of fYes, specify Cub  1 □Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh:	etc.
5-0	72 ho	eted	15. De (Specify only	cedent's Ed	ducation ade completed)		16a. Dece	dent's Usual Occu	pation during most of wo	rking	16b. Kir	nd of Business/In	dustry
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lan	ld be lental <b>ked</b> o	To Be	Adolph Rau						Emma	Reichert	:		
ary	shou and N s mar		19a. Informant's Name/Re						t and Number or R				
Σ	and 2 ealth n 27 i		Cecelia K. R	auss/	Wife								Spring , MD
Baltimore,	Pages 1 tment of H tant: If iter jury or oth		20a. Method of Disposition  1 → Burial 2 □ Crem  4 □ Donation 5 □ Ot				e of	sition (Name of natory or other pla Heaven (	Cemetery	Date Jan. 17, 2009	Si		own, State ring, Marylan
Bai	Depar mpor iny In		21. Signature of Funeral S	ervice Licer	nsee		Fr	Name and Addrancis J.	ess of Facility Collins	Funeral	Hom	e Inc.	
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	Physician /Medical		shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	E. List only	one cause on each li	ne. Э <u>То</u> Т	hrive		mg, oddir do odralo				Interval Between Onset and Death
	Examiner				Due to (or as								
		Jer	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J	b. Acute Due to (or as			re					
B	rtificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events	1	c. Prosta								
68760,	be execian a	E	resulting in death) Last		Due to (or as	a conseque	nce of):						
87	physi the b	edical		•	d								
P.O. Box 6	ath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1  Live birth 4  Pregnant a	2 Fetal d	eath 3[	Ectopic pregnar	icy		2	23d. Date of deliv Month	ery Day Year
	ss that gned by	by Ph	Part II. Other significant o	onditions	contributing to death b	ut not resulti	ing in the u	nderlying cause g	iven in Part I.				the cause of death?
ord	equire sen si ould t	ted								1 🗆	Yes 2[	XNo 3 ☐ Pro	bably 4 Unknown
ec	law i has b	Completed								24a. Was auto	DSV	24b. Were auto prior to co	opsy findings available ompletion of cause of
a F	ician: The certificate ector, pag	S								1 □ Yes	rmed? 2 <b>x</b> No	death? 1 □ Yes	2 🗆 No
Z.	siciar certif rector	Be	25. Was case referred to mexaminer?	edical	Hospital:			Ot	her:	ath (Check only			
of	Phys er this eral dir	5	1 Yes 2 No 27. Manner of Death		28a. Date of Inju	iry 2	8b. Time o	IL 3 LI DOA	XX Nursing I	Home 5 Resi			fty)
ion	nding F ath. r: After e funer.	atior	1 Natural 5 ☐	Pending nvestigation	( <i>Month, Da</i>	y, Year)	Injury		ork? ⊒Yes 2.⊒No				
Division of Vital Records,	or Attend after death Director: /	Certification: To		Could not b determined		ury - At hom c. (Specify)	e, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State	d Number or Rur )	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical C			hysician: To the best miner: On the basis of and manner st	of examination							
		Me	29b. Signature and title of	certifier	On	N	10	29c. Licer	nse number			e signed (Month,	
	10		30. Name and address of p Sayed ElSay						Rockvill	e. MD 20			
		to	21 Date filed (Month Day	Voor	32 Pegist	ar's Signatu	ra			_, 110 20	200		
	Sta Registr		JAN 1	6 20	09 Geraus	A.	pa	Ked.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 01 **Physician** 2009 CHARLES DUDLEY REED SR. 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 102 DARDEN ROAD CHESTERTOWN QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 11 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) Days Months Hours Min. Director 216-40-2685 67 10/31/1941 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Exactitiver must be notified at Director 1 ☐ Yes 2 X No MD QUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 DARDEN ROAD Funeral 21620 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Completed by Specify Specify: WHITE 3 Widowed 4 Divorced er than "natur, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **DEVELOPER** CONSTRUCTION 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked c traumatic ever ည WILMER REED GLORIA HILL LAYTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ROGER REED- SON PO BOX 54 CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. Date 20c. Location - City or Town, State 1 □ XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) WESLEY CHAPEL 01/23/2009 ROCK HALL, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN, NEWNAM FUNERAL HOME PA Kirk 130 SPEER ROAD CHESTERTOWN, MD 21620 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, also on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** CARDTO PULLEGRAN /Medical Due to (or as a consequence of): Examiner Metastalic CARCINOMIA Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed Exam and burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death Year signed by the a d be detached fo Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate performed? 1 ☐ Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျ 1 ☐ Yes 2 🚰 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 🚇 Natural Injury 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12

State Registrar JOHN C. ARRABAL VR.
31. Date filed (Month, Day, Year)

JAN 2 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.A. 223/High Stace
32 registrar's Signature

023889

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15, **Physician** Clair Rohrbaugh Month Samuel Year 2009 January 11:53a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Westminster Carroll If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F 68 Director 212-38-2428 Jan 23, 1940 ΜD. Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Hampstead Carroll MD. Director 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 4150 Black Rock Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1XX Yes 2 □ No If Yes, Give Year or Dates:1961 -1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify: white چ و 3 Widowed 4 Divorced 1967 ecedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other traumatic event, the once. carpenter White Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton C. Rohrbaugh Naomi L. Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Rohrbaugh, wife 4150 Black Rock Rd., Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hampstead Cemetery 4 Donation 5 Dother (Specify) 1/19/2009 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 Lemmer 934 S. Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical JE FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9□Unknown 9 Unknown signed by to be a detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1□ Yes 2. No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural Injury 5 Pending ithin 24 hours after death.

the Funeral Director; A pupletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one) To the within ? 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

WILA

for Street Wastrinster, MD01157

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Joyce Ann Ruleman /Medical anuary 16,2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Prince George's Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F 216-30-4275 75 Director Feb. 20, 1933 Reading, OH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ms 23a or 28a-f shot Director 1 X Yes 2 □ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6002 41st Avenue 20782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. d other than "natural", or Iten event, the Medical Evention 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify þ Hygiene. other than "natural", 3 ☐ Widowed 4 🕅 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telephone Operator Telecommunications Health and Mental Hygi em 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Albert Leo Hoelscher Irene Lasley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 Berlin Wilson Ruleman, III / Son 6002 41st Avenue, Hyattsville, MD 20782 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 1/24/2009 Brentwood, Maryland 21. Signature of Euneral Service Lica 22. Name and Address of Facility 4739 Baltimore Avenue Š SAM Gasch's Funeral Home, P.A. Hyattsville, MD 20781 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to lor as a consequence of): Examiner Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year 5 Other (specify) P.0. detached 9 Unknown 9 Unknown signed I significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate Division of Vital 1 □ Yes 2 1 No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. the the To the within ? 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Singh Gallant FoxLand, Suito 124, BOWIE, MD, 20115 14300 mi) 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 2 1 2009 Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 29, 2009

Assistant Medical Examiner

32. Registrar's Signature

Grasse C 30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Marlene Delesta Stallworth /Medical January 2009 0515 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurelwood Care Center Elkton Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F Days Hours Min. 215-58-2156 58 Director March 2, Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be putified at Director XYYes 2 □ No Maryland Cecil Port Deposit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 252 North Main Street Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2√No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced Specify. "natural" Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Wiley Mfg. Company than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is merked other the enty injury or other traumatic event, it at once. Laborer Nine Years Port Deposit, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Washington Brown ပ <u>Attee McMullen</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Eloise R.F. Akins</u> (sister) 1222 Holloway Road, Darlington, Maryland 21034. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Berkley Cemetery : 01/23/09 |Darlington, Maryland 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or coordinate). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Circhosis years /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Day 4 ☐ Pregnant at time of death Month Year signed by the a 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has 24a. Was an autopsy 1 ☐ Yes 2X☐ No 1 ☐ Yes Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) Jackders MD 10023322 1.15.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEV MD 126 A. E. Hijal. 126 A, E trigh St , Elkum MD 21921. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 1 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month LEROY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 219-20-3557 76 June 23, 1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 TNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18002 Pin Oak Road 21740 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: white 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) custodian church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles David Sheppard Leola Gelwicks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Sheppard - son 18002 Pin Oak Rd., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mausoleum 1/26/09 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Onset and Death ACRIOC Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Department of H Important: If ite any Injury or ot

permit.

**Physician** 

/Medical

Examiner

10a. State

Directo

Funeral

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Completed

Be

**Funeral** 

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Exammer and be notified at

Baltimore, Maryland 21215-0036

with the Maryland

Examiner and burial-trar cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Completed e Hospital or Attending Physician: The note hours after death.

e Funeral Director; After this certificate I letely filled in by the funeral director, page Be ၉ Certification:

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ∠ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 154 GertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0056413

29d. Date signed (Month, Day, Year) 01/12/09

Hagerstown

06/1-5

To the within 2

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN23

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Beverly Joanne Stork 2009 3:20 P January 20, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Feldspar Road <u>Middletown</u> If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 X F 220-54-2792 63 January 28 1945 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Frederick Middletown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4302 Feldspar Road 21769 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur H. Burgan Ethel Marie Farrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 Feldspar Rd. Middletown Maryland 21769 Richard Stork / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 1/24/2009 | Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Sign of Funeral Service Licenses 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 150 Wenner hours. Due to ras a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): pf pregnancy 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day time of death 5 ☐ Other (specify)

**Physician** /Medical **Examiner** 

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

within 72 hours after

filed withi Hygiene.

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item 27

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Important: If iter
any Injury or ott

altimore, Maryland 21215-0036

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Examiner attending physician for use as the buria Physician/Medical by signed by \$ Completed peen Be 2 this funeral After 1 Certification: filled in by

Division or Vital Records, e Hospital or Attending P 24 hours after death. e Funeral Director: After the To the Hospital within 24 hours at To the Funeral C completely

JH-5

State Registrar

Medical

	T
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown

performe 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24a. Was an

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day Year) investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

reduce MD 21702 AZ HEGAZÍ leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

28c. Injury at

25. Was case referred to medical examiner?

1 Tes

27. Manper of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

2 No

JAN 2 3 2009

32. Registrar's Signature back

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 7:00 P M January Hilda Lee Snider 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Williamsport Homewood Retirement Center 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🗓 F West July 22,1922 86 234-34-8487 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. States+ 10b. County 1 ☐ Yes 2 No Berkeley Martinsburg Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25403 USA 219 Shadow Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: 3 Nidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Nurse-Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Davis Blanche Richards Robert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 223 Shadow Lane Martinsburg, West Virginia 25403 Warren W. Snider - Son 20b. Place of Disposition (Name of Figure 1991) of the Part of Comments of the Part of the 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.24,2009 Pocatalico, West Virginia 4□Donation 5/Cother (Specify) Entombment Momories Mausoleum OBBOTTORE AFTORNET Facility Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 when the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimers vears 15 cas disease or condition resulting in death) Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Osteoarthritis of the 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one,

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show

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Pages 1 and 2 should be filed within 72 hours after death with

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Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit cate has been signed by the page 2 should be detached funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

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24 hours a

To the within 2.

filled in by

completely

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be Certification: To

25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month

27. Manner of Death 5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Church Koad

Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) January 20, 2009

Hagerstown Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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Sands MD Kuther 32. Registrar's Signature

State Registrar

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Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 N 29 I N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 200<sup>Year</sup> Robert Schmiech January 15, Marshall 01:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7528 Tarpley Drive Rockville Montgomery . Social Security Number 577–40–8851 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 1 → M 2 □ F Days Hours Min. Director Sept. 6, 1927 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Wodical Evar, that the could be Maryland Montgomery Rockville Director 1 □Yes 2 N No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7528 Tarpley Drive 20855 Funeral United States death 12. Was Decedent Ever in U.S. Armed Forces? 1946- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 □ No Baltimore, Maryland 21215-0036 1947 1 ☐ Yes 2 👿 No Specify 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of the Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Navy 4 and Mental Hyginis marked other 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) should be William Schmiech 2 Clara Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other traceon Patricia A. Miller (Daughter) 11804 Eton Manor Drive, #304, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 19, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State January 4 Donation 5 Dother (Specify) Silver Spring, MD 2009 Cemetery 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Ucens 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a Part 1 Inc. the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of he it ailur. List only one cause on each line. Approximate Interval Between Imm diate use (Final dise condition resulting in death) Onset and Death Immediate Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Coronary Atherosclerosis Ten Years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Jule to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ed by the a detached f P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Hypertension Completed 1 X Yes 2 □ No 3 Probably 4 □ Unknown Chronic Renal Insufficiency 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 autopsy performed? res 2 X No After this certificate 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Yes 2 🔯 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A: completely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35045 20 January 15, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum, M.D., 18109 Prince Philip Drive, #200, Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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-	Physician /Medical		disease or condition resulting in death)	a		Slage	- 0	) e w	NEWNZ							
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	10		30. Name and address of person	n who completed at	use of death (Iten	n 23a) (Type,										
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	Registr	ar	LAMI	4 2009		A A	an the	ř								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician ESTELLE** LOUISE STEPTOE 25 A M JANUARY 13 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 😾 F 579-56-1660 67 Director AUGUST 27 1941 WASHINGTON, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Widcel Example Investigated once. Director ¶∏Yes 2 ☐ No PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA 7501 VANESSA COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MARKETING SUPERVISOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MABEL AGENOR MARCUS J. CANNADY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4734 WEST CARLA VISTA DR CHANDLER, ARZONIA 85226 CLYDE STEPTOE JR./SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 1/17/09 SILVER SPRING, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Fune A Service L 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part T. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END-STAGE LIVER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OAGULOPATHY Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Acidosis MODIC attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 S Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asio 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8/18 Good Luck RD Alemu 32. Registrar's Signature 31. Date filed (Month, Day, State JAN 1 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** JANUARY 18, 2009 ETHEL MARIE SENSENEY 1:33 AN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ▼F Months Days Hours Min 90 JUNE 20, 215-28-8155 1918 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐Yes 2X No Director **OUEEN ANNE'S** GRASONVILLE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21638 116 CABIN CREEK ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2X No Specify. Completed by 3 ★ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 9 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FINNERTY SARAH CROSS WILLIAM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2734 MARBOURNE AVE BALTIMORE, MD 21230 WILLIAM SENSENEY / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CENTER, LLC 20a Method of Disposition 20c. Location - City or Town, State Department of Important: If its any Injury or o 1 ☐ Burial 2 X Cremation 3 Removal from State 1/19/2009 STEVENSVILLE, MD 4 ☐ Donation > 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD CHESTER, MD 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) neumonio /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PINO 1 Hapatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, the detached à cate has been signed I page 2 should be deta certificate has funeral director, After this death 24 hours after death Funeral Director: the filled in by To the Hospital completely

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items 23a

other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite

Pages 1 and 2 should be nent of Health and Mental

item 27 i

Baltimore, Maryland 21215-0036

within 24

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person Registrar's Signature 31. Date filed (Month

who, completed cause of death (Item 23a) (Type,

and manner stated

29c. License number 8 29d. Date signed (Manth, Day, Year)

240 36014

Print) 2001

≠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** STEVENS ALBERT E JANUAKY 1678 2009 /Medical 4a. Facility Name (If not institution give street and number)
REASANT VIEW NURSING HOME
AICL OLD NATIONAL PIKE 4b. City, Town, or Location of Death 4c. County of Death Examiner AIRY If Under 24 Hrs. MCUNT If Under 1 Year Months Days CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 2□F Hours Міл. 64 215-42-3602 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or items 23s or 28e-f shov other treumatic event. The Mudical Examination made by milling at Maryland Carroll County 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4101 old National Pike U.S. A. 21771 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 XNo þ Specify: 3 ☐ Widowed 4 XQivorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Delivery Company Truck Driver if Health and Mental Hygi item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fand Mental ! Junior Albert E. Stevens Hester Blair Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is n any injury or other treun Richard Stevens-Son 7148 Lakes End Ct. Ft. Worth, TX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1-16-2009 Smithsburg, MD Smithsburg Cramatory 22. Name and Address of Facility Louglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kartlen Zaffaron 1331 Eastern Blvd. North Hageiston 1, MD 21742 23a. Part1. Enter the disease, or connectations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death NEUMONIA DAYS-WEEKS Physician /Medical Due to (or as a consequence of): **Examiner** PROBABLE ASPINATION DAYS-WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9☐ Unknown 9 Duknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? 1 🗌 Yes 2 <u>9</u> No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of After Hospitel or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Dav. Year) MO 076499 1-16-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Dr. Mt. Airy, MD 21771 E. Miller 32. Registrar's Signature State Registrar

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Physic /Medi		Decedent's Name (First, Middle, Las     RUTH ELIZABET	,	R				2. Date of Dea Month January	th Qay	Year	3. Time of Death 1:20 P		
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Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederi	ck		y, Town or Lo						10d. Inside City Limi		
ath with the 23a or 28 ust be not	ral Director	10e. Street and Number 892 Pontiac Av				10f. Zip Code <b>2170</b>		1	Og. Citizen of United		•		
be filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evarinar rust be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ∐Yes 2 <b>X</b> If If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	14. Ra Bla Specii	ick, White,	can Indian, etc. White		
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1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than wither traumatic event, the Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last)  Elmer E.	Long,	Sr.			18. Mother's Nam			me)			
s 1 and 2 sho of Health and litem 27 is ma other traums		19a. Informant's Name/Relationship (7)  Doris Dougherty		and Number or Ru	irmont, l	MD 21	788						
permit, Pages 1 and Department of Health Important: If item 27 any lolly or other 1 once.		20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	)	C	emetery, crer i <b>nt 01</b> i	sition (Name of natory or other place  vet Cem.  Name and Addre	ce)	23.2009		ick-M	aryland		
Physician /Medical Examiner cian and cian-transit	al Examiner	23a. Part 1. Errer the disease, or come shock heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as d	a conseque	Jence of):		sumtown. I			MD	21702 Approximate Interval Between Onset and Death		
To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	y			ate of deliv	ery Day Year		
w requires that its been signed by should be detail	₽	Part II. Other significant conditions co	ontributing to death b			nderlying cause giv			bacco use con	tribute to t	he cause of death?		
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To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					Yes 2□No	28f. Location (S City or Town	treet and Num n, State)	ber or Rura	al Route Number,		
the Hospit hin 24 hours the Funera πpletely fille	Medical C	one)	ysician: To the best niner: On the basis o and manner sta	f examina	wledge, death tion and/or in	vestigation, in my o	opinion, death occu	rred at the time, o	late and place,	and due t	o the cause(s)		
With To So of So o	1	29b. Signature and title of certifier	MD completed cause of d	eath (Item	23a) /Time	29c. Licens			9d. Date signe		MD ZIT		
St Regist	ate trar	30. Name and address of person who of the sharp of the sh	32. Registra	ar's Signal	joma		son D	r, Fre	devi'C	16	MD 217	70	

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Month ILA MARIE TANNER JAN. 10, 10:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL LUTHERAN MONTGOMERY HOME ROCKVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days 577-12-0854 1 □ M 2 1 F Hours Min. 88 Director OHÍO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at MONTGOMERY ROCKVILLE MD. Director X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: WHITE 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MONTGOMERY CO. al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY SCHOOL SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental h ALBERT LOUIS DUERR MABEL ECKER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1234-TRAVIS VIEW CT., GAITHERSBURG, MD. 20879 ALBERT TANNER-SON 20b. Place of Disposition (Name of cemetery, crematory or other plac FT • LINCOLN CEM • 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/16/09 BRENTWOOD, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW 21. Signature of Funeral Sef ceiLicensee W. In HYSONG CO. 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each WASHINGTON, DC ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due t (or s a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter throughlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical attending physi for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death signed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

VEI

within 24 hours after deam

To the Funeral Director: Af

Registrar

DHMH 17 Rev 1/2001

OCME 2006

29b. Signature and title of certifie

Margarita Korell MD.

**JAN 14** 

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

January 10, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** JANHEN Raymond Edgar Tolley, Sr 20 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. Çity, Town, or Location of Death Examiner Glen Anna Baltimore Washington Medical Center Bhr mi If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 17 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **№** M 2 🗆 F 236-24-1604 Director Usual Residence of Decedent the Maryland 1∩a State 10b. County th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinating ust be retified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 ☐ No MD Howard Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8594 Old Dorsey Road 20794 12. Was Decedent Ever in U.S.
Armed Forces?

1 127°es 2 □ No 1942
If Yes, Give
Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 <u>Ş</u> 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 X Divorced 1945 White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civilian Employee Truck Driver Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roda Tolley Effie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 is permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. 3027 Old Washington Road Westminster, MD Virginia Ryan/daughter 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/19/2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Friendship Cemetery 1/09/2009 4 ☐ Donation 5 ☐ Other (Specify) Linthicum, MD Pritts Fineral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21. Signature of Funeral Service Licey 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence on burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate b performed 2 **N**O 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To patient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred † atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJZ 9+1VA 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KONZITE 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 15 Registrar

Amended Item 20b per F.D. 01/15/2009 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Phyllis 10 44 PM Thomas 200 anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F Days Hours 491-46-6240 67 Yrs Aug 11,1941 Missouri Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Charles Waldorf 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 20601 U.S.A 6204 Douglas Circle Funeral Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) P.G. County Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Is marked other than Board of Education School Teacher permit. Pages 1 and 2 should be filed w
Department of Health and Mental hygie
Important: If Item 27 Is marked other ta
any Injury or other traumatic event, the
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip S. Luedde Margaret W. Watson ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Douglas Circle, Waldorf, MD 20601 Francis A. Thomas Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 5 Other (Specify) 1/17/2009 Waldorf, MD 4 Donation Huntt Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 3035 Old Washington Road Huntt Funeral Home, Waldorf, MD M01284 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respirator **Physician** HUPOXIC day /Medical Due to (or as a consequence of) Examiner eura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical RUKEM 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ate has been signed by the atten page 2 should be detached for i Live birth 2 Fetal death 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2X No Month Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2MNo 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 🗌 No this certificate 1 Tes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) ဥ 2 ER/Outpatient 3 DOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After 1X Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ၉ Block, medical doctor Res-000 12,2009 January 30. Name and address of person who completed cause of death (Item\_23a) (Type, Print) Block, Johns 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar N 16 2009

09-00539 Linda Tisdale Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nda Tisdale		State of Maryland / Department	artment of <i>rtificate of</i>	Hea Dea	th and th	Menta	al Hyg		teg. No.	200	9 0292	
Physician	1.	edistrar . Decedent's Name (First, Middle,Last)				-31		Date of Dea	ath Day	Year	3. Time of Death 0632 hrs	
edical Examine	art -	Linda Maureen Tisdale  a. Facility Name (if not institution, give street and number)	14	b. City	Town, or Lo	ocation of		January 1		County of Deat		
	4	a. Facility Name (if not institution, give street and number)  Holy Cross Hospital			r Spring				1	ontgomery		
Funeral	5	. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)		er 1 Year	If Under	24Hrs. Min.	8. Date of B	irth(MM/DI	Forei	rthplace (State or gn	
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ore, MD stell and sho	1	Susan Bell (Mother)	5408 D. Place of Dispos	Orall sition (N	Oaks ame of cerr	Rd netery,	, Ken	bridge Date	20c. L	23944 ocation - City	or Town. State	
Baltimore, permit. Pages 1 & Documento 1 & La Importancia 1º Cilica injury, or other tra		1 X Burial 2 Cremation 3 Removal from State	crematory or ot yflower	ther plac	e)					nbridge		
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Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) Medical Examiner: On the basis of examination	ledge, death occ in and/or investig	curred at gation, ir	the time, d my opinior	ate and pl n, death o	ace, and ccurred a	t the time, d	ause(s) ar ate and pla	ace, and due t	o the cause(s)	
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Class	1	30. Name and address of person who completed cause of deat (	tem 23a)			£!	MD 04	201				
B		Zabiullah Ali, M.D. Assistant Medical Examin			reet, Bal	umore,	IVID 21	201				
St	ate	31. Date filed (Month Day, Year). 32. legistrar's Sig	nature.	ark								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Gir Irice anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hage Washington Count HOSPITA nder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Washington Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Yrs. Director Maryland 2009 Tan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expandrant man be notified at 1 Yes 2 □ No Funeral Director Maryland Washington ( 10e. Street and Number 10g. Citizen of What Country? Mulberry 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Lockic telicia Danielle Trice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother N. Mulberry St. Hagerstown, MD 21740 telicia Trice-Department of Heal Important: If Item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, MD Smithsburg Crematory 1-22-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas 21. Signature of Funeral Service Licensee A. Fier Funcral Home Kaitten 304 1331 Eastern Blud. North Hagerstown, ND 2174Z 23a. Part 1. Enter the disease, or o'm plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final via **Physician** disease or condition resulting in death) /Medical Due lo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 🗆 No funeral director. 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ⊠inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 🗆 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier

SH-0

31. Date filed (Month, Day, Year) JAN 2 2 2009

Andrew Oh

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Campus Rd 11110 Medical 32. Régistrar's Signature

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Hagerstown MD

			For State	State of Marylar	id / Dep <i>Ce</i>	artment of F ertificate of a	lealth and Death	d Mental Hy	/gien	e2009	02923
	×		Registrar     Decedent's Name (First, Middle, Last			Timeate of	Death	2. Date of D	eath		3. Time of Death
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-	Funeral	4	5. Social Security Number 6. S	ovring Home		Havre If Under 1 Year	If Under 24 H		irth	tartor)	lace (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or L	ocation				1	0d. Inside City Limits
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	er deg items ner m	nne	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Americ Black, White,	
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Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In mortant: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	cemetery, cre	ematorý or other plac Lown Gan		1/22/09		ville,Pen	,
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	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	uonoo of\:						
68760	icate be executed physician and the burial-transit				quence (ii).						
687		edical	-	d							
Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1□Live birth 2□Feta		□Ectopic pregnance	v			23d. Date of delive	,
C	he dea the at	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5	Other (specify)		<u> </u>		Month	Day Year
	ires that the de signed by the	/ Ph	Part II. Other significant conditions of	contributing to death but not res	sulting in the	underlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to the	ne cause of death?
Becords	w requires been sign should be	ed by				1100		_ 10	Yes :	2□No 3□Prob	ably 4 lanknown
راه م	e law requ has been le 2 shoul	plet						24a. Wa	s an opsy	24b. Were auto	psy findings available mpletion of sause of
-		Completed						per 1∐ Yes	formed?	death?	2 No
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	i i i i i i i i i i i i i i i i i i i	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		Oth	or.	Death (Check only			
Č		1: To	27. Many r of Death	28a. Date of Injury	28b. Time	ent 3 DOA	4 LY Nursin	g Home 5 ☐ Re 28d. Describe		6 ☐Other (Specifury occurred	y)
nders Division	Attending r death. ector: After by the fune	Certification:	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigation		Injury		k? Yes 2∐No			•	
14e	or Atte ter de lirecto n by th	rtific	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, s	treet, factory, office		28f. Location City or T	(Street a	and Number or Rura ate)	I Route Number,
tuin Vio	pltal ours at ceral D		29a. Certifier 1 CertifyIng Ph	nysician: To the best of my kno	nwledne dea	ith occurred at the ti	me date and n	lace, and due to th	0.001100/	(a) and manner as a	totad
3	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of examin- and manner stated.	ation and/or i	nvestigation, in my	opinion, death	occurred at the time	e, date a	and place, and due to	the cause(s)
	To the withing to the transfer of the transfer	Me	29b. Signature and title of certifier	hd is		29c. Licens	e number		29d. D	ate signed (Month,	Day, Year)
			Misaban	M.D			1041		1	19/09	
			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type	Print)	Unc	mb -	2107	HR.	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	2011	-, 5	. 1/	/ V · )	3	
	Regist	ar	JAN 21 2009	Senera B.	par	Ked					

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMENDED 1/21/09 PER FH AJSertificate of Death #7 CCHD Reg. N2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 19, 2009 3:01 William Washburn, Sr. Norman January /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Homestead Manor Caroline Denton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (ja yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Director 203-01-0143 July 3, 1920 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Director Caroline Maryland Denton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 410 Colonial Drive 21629 United States of America Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Š 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumetic event, the Many injury or other treumetic event, Elementary/Secondary (0-12) College (1-4or 5+) Textile Corp. 12 Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Isaac Washburn Caines Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7343 Todd's Wharf, Preston, Maryland Norman W. Washburn, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maple Hill Crematory 1/24/2009 Archbald, Pennsylvania ' 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 1969 22. Name and Address of Facility Moore Funeral Home, P.A. Denton, Maryland
12 South Second Street, Denton, Maryland audoble 11cor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cancer luna 45 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ĕ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending Injury death. 1 Tes 2 No investigation 2 Accident after death Director: filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053255 OM P009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are Preston MD 21655 136 Lednum melinda Butter 31. Date filed (Month, Day, Year) . Registrar's Signature JAN 20 2009 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	For State Registrar	State of Ma	ryland	•	rtment d tificate				giene <sub>Teg. No.</sub> 2 (	109	02925
Physicia		Decedent's Name (First, Middle,     Addie Louise	,						2. Date of Dea	th	Year	3. Time of Death
/Medica Examine		4a. Facility Name (If not institution, Dorchester Ge	give street and number)	tal		4b. City, Tov	n, or Locati		-an	4c. Count		100 10
Funeral Director		213-22-5262	. Sex 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	der 24 Hrs. Irs Min.	8. Date of Birti (Month, Day Oct. 1,	1927	9. Birthr Cour Mar	place (State or Foreign htm) yland
Maryland I-f show	or	Usual Residence of Decedent  10a. State 10b. County  MD Dorch	ester	10c. City,	Town or Loca		mbridg	re			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the last or 28a-	Director	10e. Street and Number				10f. Zip Co		.4.2		10g. Citizen of		ntry?
25	by Funeral	306 East Apple  11. Marital Status  1 □ Never Married 2 Marrier  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces?			as Decedent Yes, specify		Origin? (Sp kican, Puerto	pecify Yes or No- Rican, etc.)	14. Ra	JSA ce - Americ ck, White, y: wh:	
giene. Br than "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 11	Education grade completed) College (1-4or 5+		16a. Decede (Give ki life. De	ent's Usual 0 ind of work d O NOT use re SECTE	one during i etired)	most of work	ring	16b. Kind of B	usiness/Ine	
Mental Hy arked othe atic event,	To Be	17. Father's Name (First, Middle, La Ira D. Sanders					18. M		e (First, Middle, se Bromw		ne)	
salth and I n 27 is ma ier trauma		19a. Informant's Name/Relationship Edward J. White	, ,,						ral Route Numbe			Code) 1613
ment of He ant; If Iten ury or oth		20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1		tion (Name of atory or other y Chur		ž.	Date 22/09	20c. Location Church		
Depart Depart Import any inj once.		21. Signature of Funeral Service Lic	censee		22.	Name and A	ddress of Fa	acility Th	nomas Fu mbridge,	neral H		
hydrogen and hydrogen and hydrogen and street benual-transit and transit and t	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Card  Due to (or as a	consequence	enione of): Sten	05/5	shoc	cK_	or respiratory ar			Approximate Interval Between Onset and Death Onset Approximate Services Ser
for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 🗀 Fetal de	eath 3 🗌	Ectopic preg Other (specin					ate of delive	ery Day Year
be d	2	Part II. Other significant condition	s contributing to death but	t not resultii	ng in the und	lerlying caus	e given in Pa	art I.		bacco use con		ne cause of death?
r this certificate has been signed by the attending ral director, page 2 should be detached for use a	Completed								24a. Was a autop: perfor	sy med?	Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
is certifi director	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 🗆 EF	3/Outpatient	3 □ DOA	Other		h (Check only or	ne)		
To the Funeral Director: After th completely filled in by the funeral	Certification: To	27. Manner of Death  1  Natural 5  Pending 2  Accident investigat 3  Suicide 6  Could no 4  Homicide	28a. Date of Injury (Month, Day,	y Year) 28	Bb. Time of Injury	28c.	Injury at Work? 1 □ Yes 2	2 □No	28d. Describe h	ow injury occur	red	nl Route Number,
Funeral I	Medical Ce	29a. Certifier (Check only one)  Check only one)  Certifying  Certifying  Certifying	Physician: To the best of aminer: On the basis of	examinatio	edge, death n and/or inve	occurred at t	he time, dat	e and place, death occur	and due to the or	cause(s) and m	anner as s	tated. the cause(s)
To the comple	Mec	29b. Signature and title of certifier	and manner stat	eu.			cense numb	ser		29d. Date signe	d (Month,	Day, Year)
N		30. Name and address of person when Patricia A. J					., Ca	mbrid	ge, MD	21613		
State	е	31. Date filed (Month, Day, Year)	2000 Agistra	r's Signatur	6 1	. 4.1						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar William Wheatley George anual 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ambrid If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Hours 1⊠M 2□F 217-14-8794 88 24,1920 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 ☐ Yes 217 No Dorchester MD Crapo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2540 Lakesville/Crapo Road 21626 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 27 Married 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waterman seafood 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jabez Goldsmith Wheatley Lucy Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Wheatley wife 2540 Lakesville/Crapo Rd., Crapo, MD 21626 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 1/21/09 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Concertive disease or condition resulting in death) Due to for as a consequence of): piratia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) heartteriusc lenner Due to (or as a consequence of)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be datached for use as the burlat-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show

"natural"

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Be Completed

Medical Certification: To

Injury or other traumatic event, the Medical Examiner must be notified at

and 2 should be filed within 72 hours after tealth and Mental Hygiene.

Baltimore, Maryland

and Mental Hygiene.

Health em 27 i

permit. Pages
Department of
Important: If it
any Injury or o

**Physician** 

/Medical

Examiner

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	:	23d. Date of delivery Month Day Year	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	,	ise contribute to the cause of death?  No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes □ No
25. Was case referred to medical	26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury 28b. Time of (Month, Day, Year) 28b. Time of Work?	28d. Describe how injur	y occurred

2 Accident 8 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \* Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-15-09 D47924

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30% NOMAN THANKY BYRN

CAMBRIDGE

State Registrar 31. Date filed (Month, Day,

			1 - For State Registrar	State of N	Marylan		artment of F		nd Menta	al Hygie	ene	0000
	Physici	an	Decedent's Name (First, Middle, L.	•	TTTT T A 1			Douth		ite of Death	Pay Xa2	3. Time of Death
a.	/Media Examin		MARY  4a. Facility Name (If not institution, g  HEARTLAND NUF	ive street and numbe	,	4S	4b. City, Town, o	r Location of			4c. County of Death PRINCE GE	//300/
	Funeral Director				Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days		4 Hrs. 8. Da Min. (M	te of Birth onth, Day, Ye FUST 31	9. Birthr	place (State or Foreign
	ne Maryland Ba-f show otified at	Director	10a. State 10b. County  MD PRINCE	GEORGE'S		, Town or Lo					. 1	0d. Inside City Limits 1 X Yes 2 No
	th with th 23a or 20 1st be no		10e. Street and Number 8605 HAMLIN STRE	ET			10f. Zip Code 20785			10g.	Citizen of What Cour	ntry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decede Armed Force 1  Yes 2 If Yes, Give Year or Date:	s? <b>X</b> No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origi an, Mexican, Specify:	n? (Specify Yo Puerto Rican,	14. Race - Americ Black, White, Specify: B]		
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natur the Medical i	Completed	15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)  11th	Education rade completed) College (1-4d	or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	ation during most d d)	of working	1.0	b. Kind of Business/Ind	dustry
nd 2	be filed ntal Hygi ed other event, ti	Be	17. Father's Name (First, Middle, Las	,			COOK			Middle, Mai	GOVERNMENT den Surname)	·
aryla	2 should and Mer Is marke aumatic	J.	CHRISTOPHER SUM 19a. Informant's Name/Relationship			19b. Mailin	ng Address (Street	FRANC and Number		RTUNE e Number, Ci	ity or Town, State, Zip	Code)
e, M	1 and 2 Health a em 27 Is		JOHN WILLIAMS/S	ON	20b B	8605	HAMLIN S		LANDOV	ER, MA	ARYLAND 20	)785
mor	Pages nent of I int: If Ite		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te c	emetery, cren	sition (Name of matory or other plac LL CEMETE	′ i	Date 15/200	1	E. Location - City or To	
Balti	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		2 . Sign Hure of Funeral Service Lice	7		22	Name and Addres	ss of Facility	J. B. ROAD LA	JENKIN NDOVER	S FUNERAL , MARYLAND	HOME 20785
Z A	/sician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ratory arrest,		Approximate Interval Between Onset and Death						
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Canel	as a consellu no local no a consequ	scul		cida		-111		
8760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. AHLQ Due to (or a	nsek as a consequ Diabo	ience of):	, Cardi Molitu	,		- Dis	s cas &	
Box 6	eath certifi attending   for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pregnancy				23d. Date of delive Month	ery Day Year
Records, P.O.	w requires that the d been signed by the should be detached		Part II. Other significant conditions	contributing to death	but not resu	lting in the un	nderlying cause give	en in Part I.	23	e. Did tobaco	co use contribute to th	e cause of death?
		Completed by	Acute K	in Fra	Tarle	IM.			-   _	a. Was an autopsy performed Yes 2	prior to cor death?	psy findings available npletion of cause of 2 1 No
r Vital	hysicia his certi I directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 7 No	Hospital: 1  Inpa	tient 2 🗆 E	ER/Outpatien	t 3 DOA Othe		f Death (Chec ing Home 5		e 6 ☐Other (Specify	·/)
Division or	ing P	Certification:	27. Manner   Death  1		28d. De	escribe how in	njury occurred					
DIS	tal or Attencrs after deathral Director; ed in by the	Certif	4 ☐ Homicide determined	building,	njury - At noi etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		28f. Loc City	ation (Street y or Town, Si	t and Number or Rura tate)	l Route Number,
	the Hospital or Mihin 24 hours afte To the Funeral Dir completely filled in	Medical	one)	hysician: To the bes miner: On the basis and manner:	of examinat	vledge, death ion and/or inv	vestigation, in my o	pinion, death	place, and due occurred at th	e to the cause ne time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
1	₽ S O O O		29b. Signature and title of certifier	MD			29c. License		7		Date signed (Month, I	
1	2/0		Unay Lunigo	completed cause of	death (Item	23a) (Type, F 201ph	Print) Rd # 6	216.	Rock	ntle	MD an	852.
8	Sta Registr	_	30, Namifand address of person who completed cause of death (Item 23a) (Type, Print)  On 44 Zin 182, 4701 Randolph Rd # Zib, Rockvilla MD 2085Z.  31. Date filled (Month, Day, Year)  JAN 152009 August 18. Sparks									

State Registrar

Box 68760

P.O.

DHMH 17 Rev 1/2001

SAKUAdo

31. Date filed (Month, Day, Year)

3001

32. Registrar's Signatur

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 19. 2009 Evelyn Μ. Wedd1e 7:10 Januarv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care and Rehab Frederick Frederick If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday, If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. Months 1 ☐ M 2 🖾 F 219-20-0914 Director 96 July 30,1912 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shany Injury or other traumatic event, its Modical Evantias in must be notified. 1 ☐ Yes 2 M No Director Maryland Frederick Frederick filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6802 Ruhland Drive Completed by Funeral 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☒ No 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Unknown Emma Manahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Weddle/ 6802 Ruhland Drive, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery | Jan. 23,09 Thurmont, Maryland 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Lig 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Concestive weely /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (er as a consequence of): Examiner the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year signed by the a 5 Other (specify) □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🕱 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending spital or Attendiours after death.
neral Director: / investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

TOLL

801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Cathern 1

Sacen

1)43091

House Ave, Frederica MP 21701

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene

	_	for State Registrar					Certifica			aria ivi		_	200	9	029	30
Physicia	an	1. Decedent's Name (Fin	rs <i>t, Middl</i> e, <i>Last,</i> d. Cleon								2. Date of De Month January	ath Day	Ye 2	ar S	3. Time of De	ath M
/Medic		4a. Facility Name (If not			er)		4h City	Town c	or Location o		anuary		County of D	_	);30 E	
Examin	er			norial H	,	al	,		erick				Frede		Σ	
Funeral		5. Social Security Number	er 6. Sex	7.	Age (In yrs.		lay) If Unde	er 1 Year	If Under 2	24 Hrs.	8. Date of Bit (Month, Da		9.1	Birthpla	ce (State or F	oreign
Director		380-60-236	7	<b>I</b> M 2□F	51	Yrs	Months	Days	Hours	Min.	Feb. 2	3, 19	957 M	Countr ich:	igan	
M. J		Usual Residence of Dece 10a. State 10b	edent . County		10c. Cit	y, Town o	r Location							100	d. Inside City L	imits
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7.58a	Director	Maryland I 10e. Street and Number	rederic	:K		rr	ederic 10f. Zi	K Code				10g. Citiz	zen of What	Countr	v?	
3a or		1756 Carr	iage Wa	v				217	702			IIn	ited	States		
ms 2	Funeral	11. Marital Status		12. Was Decede		S.	13. Was Dece			gin? (Spe	cify Yes or No Rican, etc.)	_	4. Race - A	merica	n Indian,	
or ite		1 Never Married	2 Married	Armed Force 1 X Yes 2 If Yes, Give	□No	İ	1 ☐Yes				rican, etc.)		Black, W Specify:	hite, etc Wh		
Iral",	d by	3 ☐ Widowed 4 ☐	Divorced	Year or Date	es: 1979-	_										
"nati	lete	15. (Specify or	Decedent's Edu nly highest grad	cation e co <i>mpleted)</i>		(6	ecedent's Usi Give kind of wife. DO NOT (	ork done	during most	t of workir	ng	16b. Kind of Business			stry	
than	Completed	Elementary/Secondary	y (0-12)	College (1-4	or 5+)		gineeri			cian		U.S. Go			nment	
other ent,	Be C	17. Father's Name (First,	, Middle, Last)				5				(First, Middle					
rked rked tic ev	To B	Arthur L.	Wise						Co	ra M	ight					
s ma		19a. Informant's Name/F	Relationship (Ty	pe. Print)		19b. M	lailing Addres	s (Street	and Numbe	er or Rura	l Route Numb	er, City or	Town, State	e, Zip C	Code)	
n 27 i		Mary Wise	/ Wife			175	56 Carı	ciage	e Way	Fre	derick	, Mar	y1and	21	702	
or of H		20a. Method of Disposition 1   ■ Burial 2 □ Cre		lamoural from Ctr	20b. F	lace of Demetery,	isposition (Na crematory or	me of other pla	ce)	Janua	ate	20c. Loc	cation - City			io
tant:		4 □ Donation 5 □				lem (	Cemeter	У	1 1	22 <b>,</b>	2009	S1an	West Virg lanesville,			та
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Runorel	Service License	ee /			22. Name a	ınd Addre	ess of Facility	y Sta	uffer l	Funer	al Ho	nes	, P.A.	
D 2 8 0	_	22. Name and Address of Facility  Stauffer Funeral Homes, P.A.  1621 Opossumtown Pike Frederick, Maryland 21702  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate													702	
		shock, or heart failure. List only one cause on each line.  Interval Betwe												en ath		
ıysician Medical		disease or condition resulting in death) a. //E/H3/H111( //HV(IZEW7)1( //HV(E/E											1			
kaminer		Due to (or as a consequence of): $SFPSTS$														
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nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	\$ <b>\$</b> ,	PNEU												
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ng physician and as the burial-transit	Medical		L.	i												
ing pl	Med	IF FEMALE:		V												
or us	ian/	23b. Was decedent preg in the past 12 mont	filatic		th 2□Feta	death	3 🔲 Ectopic		су			2	3d. Date of Month		y Day Yea	ir.
the shed f	Physician/l	1 □ Yes 2 □ No 9 □ Unknown		4 ∐ Pregna 9 ☐ Unknov	nt at time of c n	leath	5 Other (s	pecify) _					WOTET		ay rea	
ed by detac		Part II. Other significant	t conditions cor	ntributing to deat	h but not resi	ulting in th	ne underlying	cause giv	ven in Part I.		23e. Did	tobacco us	se contribute	to the	cause of deat	th?
n sign Id be	d by	ANEMI	A								1 🗆	Yes 2	]No 3□	Proba	bly 4∰Unk	nown
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te hes	m C	7 1107	2,40.								auto	psy ormed?	prior death	to com <sub>i</sub> i?	pletion of caus	e of
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is cer direct	To B	examiner? 1 ☐ Yes 2 ANo	F	lospital:	atient 2 🗆	ER/Outpa	atient 3 🗆 D	OA Oth	ner: —		ne 5 ☐ Resi		□Other /S	necify)		
fter th	Ľ:	27. Manner of Death 1 Natural 5	☐ Pending	28a. Date of		28b. Tim Inju		28c. Inju Wor			28d. Describe			podity		
or: All	atic	2 Accident	investigation	(/// 5/////	24, 144,	,-	M		Yes 2 □	No						
irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be building, etc. (Specify)								2	8f. Location ( City or To			Rural	Route Number	,
urs al																
within 24 hours after death.  Vo the Funeral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 12 (Check only one)	Certifying Phys Medical Exami	sician: To the be ner: On the bas and manne	is of examina	wledge, c tion and/o	death occurre or investigatio	d at the to n, in my	ime, d <i>a</i> te an opinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) date and	and manne place, and o	r as sta lue to t	ited. he cause(s)	
within Го the ротрі	Me	29b. Signature and little	pf certifier				29	c. Licens	se number			29d. Date	e signed (Mo	onth, Da	ay, Year)	
		> Starle	MD					Do	0634	98		1/1	9/09			
140		30. Name and address of	of person who co	mpleted cause	of death (Iten	n 23a) (Ty	pe, Print)					. / /	170.			
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Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

31. Date filed (Month, Day, Year)

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	iryland		artment of rtificate			Mental Hy		2009	02931	
	Physicia		1. Decedent's Name (F Mary	Madeline Whi			te -M				ate of Death  Month  Day  Year  On 1 2 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			4b. City			y, Town, or Location of Death			4c. County of Death			
/	Funeral		Civista /	Medico ber 6. Se	Center X 7. Age		ıst birthday)	If Under 1	Year   If	1101 Under 24 Hrs.	8. Date of Bi	rth	Charl.	place (State or Foreign	
	Director		217–46–8118		□M 2🖾 F	63	Yrs.	Months D	Days H	lours Min.	8. Date of Bi (Month, D Feb. 4,	1945	Was	hington, DC	
yland	show		Usual Residence of De 10a. State 10	Db. County		10c. City,	Town or Loc	cation						10d. Inside City Limits	
ne Mar	8a-f sl	Director	Maryland	Charles		Wal	.dorf							1 ☐ Yes 2 🛣 No	
with t	3a or 2	JE DI	10e. Street and Number 5810 Opaley					10f. Zip Co	ode 603			10g. Citi	izen of What Cou USA	ntry?	
er death	tems 2	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?		i. 13. V			nnic Origin? (Sp Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	can Indian, etc.	
72 hours after death with the Maryland	ral", or items 23a or 28a-f shov Examilier must be mutilled at	þ	1 ☑ Never Married 3 ☐ Widowed 4 ☐		1 ∐Yes 2 🔯 N If Yes, Give Year or Dates:	lo	1	l∐Yes 2x	No S	pecify:			Specify: Who		
72 ho	natura Geal B	leted	15 (Specify	. Decedent's Edu only highest grad	cation le completed)	11	(Give	dent's Usual C kind of work o	done durin	n ng most of worl	king	16b. Ki	nd of Business/Ir	dustry	
filed within	giene.	Completed	Elementary/Secondary (0-12) 2 College (1-4or 5+)				Statistical As			istant			Federal Government		
be file		Be	17. Father's Name (Fire		to In						e (First, Middle	, Maiden	Surname)		
should be		은	Asbury Ro				19b. Mailin	g Address (S		Lucille Number or Ru	Conte	oer, City o	r Town, State, Zi	o Code)	
1 and 2	Health am 27 is her tra		Linda Marie T		ster					untingto	wn, Maryl		20639	·	
Pages 1	ent of h nt: If ite y or ot		20a. Method of Dispos 1 <sup>™</sup> Burial 2 □ C 4 □ Donation 5 [	remation 3 □ F	Removal from State	ce	metery, cren	sition (Name natory or othe on Cemete	r place)	01/21	Date /2009		cation - City or To ton, Mary]	-	
permit. F	Dapartme mportan my Injur		21. Signature of Funer			11000	22	. Name and A	Address of	f Facility Geo	rge P. Ka	ılas F	uneral Hon	ne P.A.	
		11	6160 Oxon Hill Road Oxon Hill, Maryland 20745  23a. Latt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										J/45 Approximate Interval Between		
	hysician /Medical xaminer		Interval Between Uniterval Between Onset and Death disease or condition											Onset and Death	
			Due to (or as a consequence of):												
pa	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Entor Underlying Cause (Disease or injury												
execut	n and ial-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C.   Due to (or as a consequence of):												
ificate be executed	physician and tha burial-transit	edical			d										
			IF FEMALE: 23b. Was decedent pro	egnanı	23c. If yes, outcome of			75-4:					23d. Date of deliv	ery	
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as that	gned b	by Ph									se contribute to t	he cause of death?			
raquira	this certifical director, p									□ No 3 □ Pro	bably 4 🗹 Unknown				
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clan:		Be Co	25. Was case referred examiner?	10	tara Vali					. Place of Dea	1 □ Yes th <i>(Check only</i>		1 □ Yes	2 E I NO	
Phys		n: To									Residence 6 Other (Specify)				
tending		ertification:	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation					ib. Time of Injury at Work?  M 1 □ Yes 2 □ No							
al or At		ertifi	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospita	24 hours Funera etely fille	ledical C	29a. Certifier 12 (Check only one) 2	Certifying Phy Medical Exami	sician: To the best of ner: On the basis of and manner sta	examinati	rledge, death on and/or inv	occurred at vestigation, in	the time, o	date and place on, death occu	, and due to the rred at the time	e cause(s) , date and	and manner as: place, and due t	stated. o the cause(s)	
To the	within <b>To the</b> comple	Me	29b. Signature and title	of certifier	and manner sta	ieu.		29c. L	icense nu	mber		29d. Dat	e signed (Month,	Day, Year)	
	0		1	Jell				D-	000	0277	3	i/	13/00	7	
2	0		30. Name and address	of person who co	mpleted cause of de	eath (Item :		Print) Ve L	a F	Plata	MD. 2	06	46		
	Stat Registra		31. Date filed (Month, I	Day, Year)	32. Registra	r's Signatu	ire	V- L		W 100	· · · · · · · · ·		· KJ		

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Please	Type or Prin						•		•			
		State of Maryland / Department of Health and Me 1 - State Registrar Certificate of Death							Mental Hy	ental Hygiene Reg. No 2009 02932				
		Decedent's Name (First, Middle, L.)	ast)	Gertificate of Death					2. Date of De	eath		3. Time of Death		
Physicia /Medio		Rosetta		Jan.				18,	ay Year 2009	1.35 A. <sup>M</sup>				
Examin	er	4a. Facility Name (If not institution, g.		4b. City, Town, or Location of Death					c. County of Dea					
Funeral		4829 69th Place 5. Social Security Number 6.	Sex 7. Age	e (In yrs.	last birthday)	If Unde	ttsv.	If Under 24 Hrs.		rth	rince Ge	thplace (State or Foreign		
Director		244-54-9781 Usual Residence of Decedent	Yrs.	Months Days Hours Min. (Month, Day, Year) Country) April 29,1936 North Caroli										
yland now		10a. State 10b. County	y, Town or Lo	r Location						10d. Inside City Limits				
e Mar 8a-fsl	Director	Maryland Prince G	eorges	Hyat	tsvill							17X Yes 2 □ No		
with the Sa or 2	Dir	10e. Street and Number 4829 69th Place				10f. Zip Code					Citizen of What C	ountry?		
death	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.	S. 13.		0874 edent of H	lispanic Origin? (S		S.A. 14. Race - Am				
be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Extrair or most be rediffed at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No				13. Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☑ No Specify:					Black, Whit	<sub>e, etc.</sub> Black		
2 hours atural' cal Ex	To Be Completed b	15. Decedent's Education 16a. Dec					ual Occup	pation	<u> </u>	16b. Kind of Business/Industry				
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iled wi Hygier Iher th nt, Ibs		10 Homemaker  17. Father's Name ( <i>First, Middle, Last</i> )  18. I						19 Mother's Nor	Own Home other's Name (First, Middle, Maiden Surname)					
ld be f lental ked o		James Davis						Ollie Ma						
2 shou and N is mar aumat							iling Address (Street and Number or Rural Route Number, Co					Cify or Town, State, Zip Code)		
1 and 1 Health Sm 27 ther tr		Ann R. Watkins  20a. Method of Disposition	(daughter)	20h 5				ce Hyati	tsville,			T Class		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Examination must be retified at once.		Method of Disposition  1 Surial 2 □ Cremation 3 I  4 □ Donation 5 □ Other (Spec			Place of Dispo emetery, crer terson						Location - City or			
rmit. F partme portar y injur		21. Signature of uneral Service Lice	-	Fat							urel Hil Funeral			
permi Depa Impo any is		9013 Annapolis Rd. Lanham, MD 20706												
		23a Bart 1. Enter the disease (or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final												
Physician /Medical		disease or condition resulting in death)  Lung Cancer  Due to (or as a consequence of):										Jnknown		
Examiner	al Certification: To Be Completed by Physician/Medical Examiner													
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leath certificate attending physi I for use as the k		IF FEMALE:	23c. If yes, outcome	of pregna	ancy	****					22d Date of de	li rama		
or Attending Physician: The law requires that the death certificate siter death.  Director: After this certificate has been signed by the attending physi in by the funeral director, page 2 should be detached for use as the t		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No							23d. Date of delivery  Month Day Year					
w requires that the d s been signed by the should be detached		9 Unknown	9 Unknown		ulting in the			- in Don't	224 Did	A=b====				
uires th		Part II. Other significant conditions contributing to death but not resulting in the und					cause giv	en in Part I.		I tobacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably ★□ Unknown				
sw request speer									24a. Was			utopsy findings available		
The law cate has page 2 s									auto perf 1 □ Yes	psy ormed? 2 A N	prior to	completion of cause of s 2 □ No		
ician: certific ector,		25. Was case referred to medical examiner?	Hospital:				Oth	26. Place of Dea						
g Phys er this eral di		1 ☐ Yes 2 ☑ No 27. Manner of Death	ent 3 DOA Other: 4 Nursing Home 5 Res				sidence 6 Other (Specify)							
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or Attu Ifter de Directo in by ti		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. L.									Location (Street and Number or Rural Route Number, City or Town, State)			
spital nours a neral C		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical Example)	aminer: On the basis of and manner sta	f examina	tion and/or in	vestigatio	n, in my c	opinion, death occu	urred at the time	, date ar	nd place, and du	e to the cause(s)		
Vith Vith	Σ	29b. Signature and title of certifier . 29d. License number 29d. [										Date signed (Month, Day, Year)		
1		30. Name and address of person who completed cause of death (Item 23a) (Tube, Print)									nuary 20, 2009			
		Maria Farooqi,	MD 1160 Va	rnum	St. N	,	l Wa	shington	, D.C.	2001	.7			
Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jan. 1<sup>a</sup>4, 2009 5:30 PM Quillie Mae Warren /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) 10-19-27 Birthplace (State or Foreign Country) Louisiana 10d. Inside City Limits MYes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Private 18. Mother's Name (First, Middle, Maiden Surname) Allie Crawford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 9531 Acorn Park St. Capitol Hgts. Md. 20c. Location - City or Town, State Clifton, Louisiana Hackett's Funeral Chapel, Inc. 23a. Prit 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mouth 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02934 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Wheatley James 23, 2009 Jan. 2:55 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ★M 2 □ F Maryland 217-30-8577 72 Director Feb. 7, 1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or items 990 ming ny injury or other traumatic event. 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 DXYes 2 □ No Director Baltimore MD 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 264 S. Highland Avenue 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 Smith's Auto Glass College (1-4or 5+) Upholsterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Harry Wheatley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 S. Highland Avenue Balto. Md. 21224 Minnie Wheatley - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Reg 1-24-2009 Hanover, MD 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Joseph N. Zannino
Joseph 263 S. Conkling St. Balto.Md 21224 Jr. Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disc se con shock, or heart fall recursions. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tonly in the cause on each line. Approximate Interval Between Onset and Death Immediate Ca Final disease or condition resulting in death) **Physician** Cerebrovasular accident 2 weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urosepsis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Pulmonary embolus 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospice 1∐ Yes 2⊠ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

law requires that the death certificate be executed attending physician and for use as the burial-trar Box 68760, Ö ۵. Records, The Division of Vital After 1 Director: Medical

Hospital or Attending Physician: 24 hours after death. 24 hours a within 2 To the I

33/09

1 State

31. Date filed (Month, Day, Year) Registrar

mil

29b. Signature and title of certifier

(Check only one)

620 Boulton 32. Registrar's Signature

and manner stated.

MP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POIK

**ORIGINAL** 

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Street Bel Air MP

(MO)

29d. Date signed (Month, Day, Year)

1-23-09

DHMH 17 Rev 1/2001

Please Type or Print in Throughout by how densure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea, No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Levellis WIlliamson /Medical 24 2009 Jan. 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 5 Social Security Number 220-62-6332 22-62-8332 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 54 10/10/1954 Wash.D.C Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experience in ust be notified at Director 1 ☐ Yes 2 ☐ No MD P.G. Suitland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4245 Silver Hill Rd#1 20746 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) : 1 and 2 should be fill ! Health and Mental H tem 27 is marked oth other traumatic even Be Edward Williamson Sr. 2 Rebecca Curry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Williamson/brother permit. Pages 1 and:
Department of Health
Important: If Item 27,
any Injury or other fra 7205 Crain Highway Upper Marlboro, Md20772 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Trinity Mem. Cem 4 Donation 5 ☐ Other (Specify) 1/30/09 Waldorf Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards Ellward Hill RD.Suitland, Md20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) rediate Cause (Final order Physician harso /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tra P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 5 Other (specify) 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 24 1 ☐Yes 25. Was ce referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 🔼 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death After t 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 🗌 No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

And manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who (Item 23a) (Type, Print) 62 filed (Month, Day, Year) Redistrar's Signature 32. State

DHMH 17 Rev 1/2001

Registrar

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		•	For State Registrar	State of Mary	·	rtificate of		F	Reg. No. 20	9 02936
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea		3. Time of Death 8:23 Р м
	/Medio		JOSEPH WAYNE  4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of I	
فري	LAdilliii	CI	FREDERICK MEMORIA	L HOSPITAL		FREDE			FREDI	
	Funeral Director		5. Social Security Number 6. Social Security Number 215-42-3451  Usual Residence of Decedent		yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day July 7,	<sup>h</sup> Year) 9. 1946	Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar Ba-fsl	Director	Maryland Freder:	lck	Frederic					1X Yes 2 □ No
	with th		10e. Street and Number			10f. Zip Code 21701			10g. Citizen of Wha United	•
	ns 23	Funeral	405 Columbus Aven	12. Was Decedent Ever	in U.S. 13.		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Michael Eventhar must be nuffied at once.	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cub 1 □ Yes 2 X No		o Rican, etc.)	Specify:	<sub>Vhite, etc.</sub> √hite
2-0	72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Busin	ess/Industry
121	within iene. than	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	lire.		preneur		Trans	portation
ק	be filed trail Hygist of other event, III	Be C	17. Father's Name (First, Middle, Last)				•	ne (First, Middle,	Maiden Surname)	
Maryland	should b and Ment s marked umatic e	2	Charles Francis						erine Redr	
Mar	und 2 sh alth and 1 27 Is m er traum		Nancy Wallace /	ype. Print) Wife	1				er, City or Town, Sta k, Maryla	
ē,	s 1 and of Health item 27 other to		20a. Method of Disposition	2	20b. Place of Dispo cemetery, cre		!	ary 30,	20c. Location - Cit	
<u>ii</u>	Pages ment of ant: If ite		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	mithsburg	Crematory	20	009  :		g, Maryland
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any injury or othe		21. Signature of Funeral Service Licen		01473 K	2. Name and Addr eeney and 06. Fast (	ess of Facility d Basford Church St	PA Fune	eral Home	Maryland 21701
			23a. Part 1. Enter the disease or composhock, or heart failure. List only of	lications that caused the	death. Do not en	ter the mode of dy	ing, such as cardia	or respiratory ar	rest,	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Meta		ancer				Onset and Death
-	/Medical Examiner			Due to (or as a co	nsequence of):					
	D +	ner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to or as a co	nsequence of):					
	ecutec and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co						
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687	tificate ig phys as the	ledical		d						
O. Box	w requires that the death cer been signed by the attendin should be detached for use	Completed by Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnan ☐ Other (specify)	осу		23d. Date o Month	,
σ.	that the	/ Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
rds	quires en sigr uld be	ed b						1 🗆 Y	′es 2 □ No 3[	Probably 4 Unknown
eco		plet	1					24a. Was autop		re autopsy findings available r to completion of cause of
<u>=</u>	The ate pag	S						perfor 1 □ Yes	rmed?/ dea	th?  Yes 2 □ No
<b>∠</b> it	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatie	at all pos Ot	hor:	ath (Check only o		(A / A
1 of	g Phy ter this teral d	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day, Ye	28b. Time o		iry at	T	dence 6 Other occurred	<i>Specity)</i>
sior	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident investigation			M 1	Yes 2 □ No			
Division of Vital Records,		Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (5 City or Tow		or Rural Route Number,
	e Hospital or 24 hours afte Funeral Dir etely filled in	Medical		yslcian: To the best of m liner: On the basis of exa and manner stated.						
	To the within 2 To the complete	Me	29b. Signature and title of certifier				se number		29d. Date signed (A	Month, Day, Year)
			Shum	<u> </u>		81196	14070		1/27/0	9
			30. Name and address of person who				D	-1- M	.lomd 047	)1
	Sta	ite	Safrina Hasan, N 31. Date filed (Month, Day, Year) FEB 0 2 200	1.D. 400 Wes 32. Registrar's	Signature		, rrederi	ck, Mary	land 2170	JI
	Pegist		FFR 0.2.200	of Vlances	A Roma	1 de la secono				

DHMH 17 Rev 1/2001

		•	State Registrar	,	Certificate d	of Death	Reg.	No. 2009	0293
	Physici	an	1. Decedent's Name (First, Middle, Last	1 1 4			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Satorious		sner	and and an of Book	01 2	3 200	2037
	Examin	er	4a. Facility Name (If not institution, give	Memorial Campu	s	n, or Location of Death		4c. County of Death	
*	Funeral		Western Maryland 1 5. Social Security Number 6. Se	x 7. Age (In yrs. la	ast birthday) If Under 1 Ye		8. Date of Birth (Month, Day, Ye	Allegany 9. Birthp	place (State or Foreign
	Director		236-28-0186	<b>X</b> M 2□ F 85	Yrs. Months Da	ays Hours Min.	Nov. 4,19		mington, M
3	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	/, Town or Location			1	0d. Inside City Limits
1	Maryii f sho	호	UV Minom		N				1 ☐ Yes 2 No
	r 28a	irec	WV Mineral  10e. Street and Number	L	New Creek 10f. Zip Co	de	10g.	Citizen of What Coun	ntry?
1	23a o	Funeral Director	Midway Lane		2	6743		USA	
1	ems	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	<ol> <li>13. Was Decedent</li> </ol>	of Hispanic Origin? (Spec Cuban, Mexican, Puerto R	cify Yes or No- ican, etc.)	14. Race - Americ Black, White, e	
9	or II	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give	_ 1 ☐ Yes 2 📆	No Specify:		Specify:	
0000-	s 1 and 2 should be lined within 72 hours after death with the Maryland of Health and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the "hedical Examinating to neithed at		15. Decedent's Edu	Year or Dates: WW I	16a. Decedent's Usual O	ccupation	16b	Kind of Business/Ind	nite dustrv
2 F	an "na	Completed	(Specify only highest grad Elementary/Secondary (0-12)		(Give kind of work de life. DO NOT use re	one during most of working	7		,
7	ould be filed with Mental Hygiene arked other that atic event, the	မြ	6	College (1-401-04)	Calendar M	achine Opera	tor	Paper Mil	1
מום	d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Maid	fen Surname)	
<u> </u>	i Men Marke Marke	욘	Edward Whisner		T		Elizabe		
	and 2 sho ealth and m 27 is ma her trauma		19a. Informant's Name/Relationship (T)	_		reet and Number or Rural		ty or Town, State, Zip	(Code)
٠ ,	Tand 2 Health tern 27 i		Jerry E. Whisner		lace of Disposition (Name of emetery, crematory or other	55 New Cre		26743 . Location - City or To	wn, State
5	8 <del>= 5</del>		1 Burial 2 Cremation 3 ☐ F	Hemoval from State		Jan.		7 III	,
	- 돈만 등		21. Signature of Euneral Service Licens	1010	Omac Memorial 22. Name and A		009   I th Funera	<u>Keyser, WV</u> al Home	
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			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death ne cause on each line.					Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	Acte	Musica- V.	al Interes	40-		Onset and Death
A. C.	/Medical Examiner	Ш	resulting in death)	Due to (or as a consequ	ience of):		17.		
	- Adminior	<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequ	ience of).			-	-
pu-	ured insit	Examine	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0) 40 4 00110044	01,0				
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	ing ph	Medical	IF FEMALE:						
ה מ	am ce uttend or use		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3 Ectopic pregr			23d. Date of deliver	ery Day Year
5	the a	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 ☐ Other (specif	y)			,
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ecords,	quires n sigr ald be	Completed by	Coronery As	tory Kisza	· 5 %		1 ☐ Yes	2 No 3 Prob	pably 4 Unknown
2	s bee	sete		/			24a. Was an	24b. Were auto	psy findings available
ב ב	ate ha	E					autopsy performed 1 Tes 2	death?	mpletion of cause of
VII	entifica ctor, p	Be C	25. Was case referred to medical examiner?		/	26. Place of Death		112100	
> i	nysic this co		1 ☐ Yes 2 M/No		ER/Outpatient 3 ☐ DOA			e 6 ☐Other (Specif	у)
	After After funera	ië Bi	27. Manuer of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)		Injury at 29 Work? 1 □ Yes 2 □ No	3d. Describe how it	ijury occurred	
2	death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho			Rf. Location (Street	t and Number or Rura	al Boute Number
	after after Direct	Certification: To	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, Si	tate)	, riodio rambol,
- 4	Spira hours ineral y fille			vsician: To the best of my know					
3	To the hospital or Attending Priystcian: The law requires man the deam certificate be executed within 24 hours after death.  within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exami	iner: On the basis of examinat and manner stated.	tion and/or investigation, in	my opinion, death occurre	a at the time, date	and place, and due to	tne cause(s)
- 4	Vith To t	Σ	29b. Signature and title of certifier	2 -4 2	/	cense number	29d.	Pate signed (Month,	Day, Year)
			14/29 1.00	-	crysician [	163118	1/	-3/1	
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	110	und		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signati	ture	m belan			
	Registr		FEB 0 2 200	la.	9. parker				

DHMH 17 Rev 1/2001

2:42 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

35 MIN

Year

1 ☐ Yes 2 No

<u>Pennsylvania</u>

White

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kenneth James Young 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 2 M 2 □ F Yrs. Director 199-52-5541 Jan.6, 1958 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the "Marked Exprining Trust be notified at any injury or other traumatic event; the "Marked Exprining Trust be notified at any injury or other traumatic event; the "Marked Exprining Trust be notified at any once." 10b. County 10c. City, Town or Location 10a. State Be Completed by Funeral Director Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12211 South Debkay Court 21770 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2½ No Specify. Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Design Engineer Bechtel Power 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Young ပ Lorraine Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammie A. Young/ Wife 12211 South Debkay Court, Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 21, 2009 Germantown, Maryland Souls Cemetery 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ordioc. /Medical Duerto (or as a consequence Examiner newlar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the model. Myocardial Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy neral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for i in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐Yes 2⊠No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No NIA 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide NIA 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1118/09 YSICIAN MDD66599 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 130 2009 2:35 PM Month **Physician** January Milford L. Adams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Manyard Heath Care St. 5. Social Security Number 6. Sex 7. Age (In yrs. Perry Point recil 8. Date of Birth (Month, Day, Year, Apr 11, 1918 Birthplace (State or Foreign Country) **Funeral** Min. 1**X**XM 2□ F Months Days Hours 90 VA 215-38-9377 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Madical Experience to the confined and pose. Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 1439 Virginia Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 XX es 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. \$ White 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer MD Dept of Corrections dame known to P 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos T. Adams Emily L. Gilliam ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1441 Virginia Ave, Severn, MD 21144 Milford C. Adams Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baldwin UMC Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State N⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 5, 2009 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licen Name and Address of Facility Fink Funeral Home, P.A. K. 426 Crain Hwy S., Glen Burnie, MD 21061 Gregory/Kink 23a. Part 1. shock, Enter the disease, or or heart failule. Lis ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, guse on each line. Approximate Interval Between Onset and Death Immediate Can e (Final disease or condition resulting in death) Due to (r as a consequence of): **Physician** Un Known /Medical Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Day 5 Other (specify) signed by the a i be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification; To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of after death.

Director; After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 17€Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a 24 hours a 🜠 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Signature System, Perry Point, MD 21902

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Physic /Med

Exami Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year Generoso G. Alejandro Februari /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death t05011 ase Age (In yrs last birthday) 5. Social Security Number 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1X M 2 □ F Director 217-94-8922 June 27,1949 Philippines | Usual Residence of Decedent death with the Maryland 10a. State 10b. County Show 10c. City Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Expriner must be notified at Director 1 ☐ Yes 2 🗓 No Md. Balto Rosedale 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 5412 McCormick Avenue 21206 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 1 ☐ Yes 27 No Specify: \$ Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene, important; if item 27 is marked other than 'any injury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance <u>Hospital</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilio Alejandro ၉ Natividad Geronimo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Cabug-os Spouse 5412 McCormick Avenue Rosedale, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 TD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2-7,2009Balto. City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as | consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and burlal-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 💢 No 3 Probably 4 Unknown Completed Hospital or Attending Physician: The law cate has t page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 4M D0060560 1,2009

Registrar
DHMH 17 Rev 1/2001

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32. Registrar's Signature

30. Name and address of percent who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

amend #30 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MALACHI 2009 24 3:48 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner <u>Greater Baltimore Medical Ctr</u>
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Towson If Under 1 Year Baltimore Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, **Funeral** NONE 1 M 2 □ F Days Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modest Examinations the nutfined at Yes 2 ☐ No Director TTINGHAM MD 10g. Citizen of What Country? 10e. Street and Number MD-USH STONEWAY by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 - ARMSTRONG 1 ☐Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARMSTRONG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 20c. Location 20b Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vic Linensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) PILAMATURIT IHY 32 MIN **Physician** EXTIEME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 **Z**Nc 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗌 No investigation 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01/26/2009 Dorocarin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard J. Birenbaum G.B. M.C. Baltimore, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Darke Registrar

			Plea	se Type or													
		For State Registrar		State of	of Maryl	and / [		artment rtificate			nd M	ental Hyg F	giene Reg. No.	20	109	029	43
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/Medic	al		Marion	Dolores	Acqu	ista		4h Cihi To		Lanating of E		January	_		009	12:15 P	D M
Examin	er	4a. Facility Name (/	ban Hos		umber)					Location of D	Death		4c. County of Death  Montgomery				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Eracii act must be notified at once.	/ Fun	1 Never Marri		Armed F	orces? 2 <b>∏</b> No		'	fYes, specify 1 □Yes 2¶S	/ Cubai	n, Mexican, P Specify:	Puerto F	Rican, etc.)			ck, White,		
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the I completely filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 2	months? No		birth 2 🗀 F gnant at time	etal death		Ectopic pred					2		ite of deliv	ery Day Year	r
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NORMA 1025 AM ABRAMS 7009 FEBRUMMY /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 01/15/1942 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 215-40-2978 **Director** 67 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 □Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3411 OLD COURT ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No 9 Specify: WHITE 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESPERSON F00D permit. Pages 1 and 2 should be filed be permit of Health and Mental Hygin Important: If item 27 is marked other: any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ISADORE** ROCHMAN JEAN SILVERBLATT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND ABRAMS / HUSBAND 3411 OLD COURT ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date LIBERTY PARK OF 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION 22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 02/03/2009 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pancreation Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🛫 and -trans that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-t Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 🗷 No page ; certificate 2 🗆 No or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Certification: To 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the | within 2 To the | 29b. Signature and title of certifier

State Registrar

0

DHMH 17 Rev 1/2001

2835

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D66616

31. Date filed (Month, Day, Year)

H45931

SMITH AVE SUITE ZOS Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 12:40 AM Month **Physician** January 31, 2009 Gloria Dawn Barley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6811 Highbridge Road Prince George's Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Yrs. 69 Director 12, 1939 Washington, DC 578-54-7019 Oct. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f show the Medical Example in until be notified at YYes 2 No Director Prince George's Bowie Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20715 6811 Highbridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Service Technician Lazy Boy Furniture 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Brandt ပ Foye Barley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trau Frederick Barley/ Brother 6811 Highbridge Road Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/5/2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee qui 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ATheroscheroTic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed? Yes 2 No certificate 2 No 1 □Yes 1 ☐ Yes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After y filled in by the funera Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVAdo Hos 3001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Manth, Day,-Year

Registrar's Signature

09-00814 Donald Buckler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 02946

				For State		Certificate of Death							Reg. No.				
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<u>{</u>			4a	. Facility Name (if not institution, give 12729 Millstream Drive	street and nur	mber)		4b. City, Tov Bowie	vn, or Lo				Р	rince G	eorge's		
	Funeral		5.	Social Security Number 6. Se.	(	7. Age (In yrs. la	st birthday)	If Under	1 Year Days	If Under Hours	24Hrs. Min.	1			Foreign	place (State or Washing	ton
	Director			577-46-4871 1X	M 2 F	73	Yrs	Months	Days	Hours	. IVIII I.	May 2	2, 19	35	Cour	ntry) DC	
		7	_	sual Residence of Decedent  10b. County		10c. City.	Town or Loca	tion	_							10d. Inside City I	Limits
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	th the Maryland 23a or 28a-f sho notified at once.	Dispetor	۱۱ اظ		Destro			207	15				USA				
	, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. Item 77 is marked other than "natural", or items 23a or 28a-f she reamerie event, the Medical Examiner must be notified at once	1 5	2 1	12729 Millstream  . Marital Status	12. Was Dec	cedent Ever in U.	s. 13. W	as Decedent	of Hisp	anic Orig	in? (Spe	ecify Yes or	No-		- Americ e, etc.	an Indian, Black	
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	17215-0036 Id be filed within 72 hours after Antal Hygiene. Anarked other than "natural", preprint, the Medical Examiner	1	<u> </u>	15. Decedent's Education (Specify or	nly highest gra	de completed)	16a. Decede	ent's Usual O most of worki	ccupations	on (Give k DO NOT	kind of w use retir	ork done ed)		Kind of Bu		f Columb	
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	5-0036 led within 7 Hygiene. I other than	no la	ĔL	12			Firem	an	1	8.Mother	s Name	(First, Midd				Cincilo	
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	2121 ould be fill Mental I marked	E   C	9   0   1	Henry Warfield Bu	ype, Pnnt )		19b. Maili	ng Address	(Street	and Num	ber or F	Rural Route	Number, C	City or Tov	wn, State,	Zip Code)	
	MD 2 d 2 shou lth and h n 27 is n	ושמו	-1	Susanne Shaw/ St		hter	8733	Conte	e R	oad A	Apt.	103	Laure	1, M	D 20	708	
	and 2 and 2 lealth litem 2	Lan		Oa. Method of Disposition		20b.	Place of Disp	osition (Namother place)	e of cen	netery,		Date	20c.	. Location	- City or	Town, State	
	lore littori	e de la composition della composition della comp		1 X Burial 2 Cremation 3		rom State Ve	crematory or Maryla terans	Cemet	ery		2/3	/2009				e, MD	
	Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. If the To I amarked other the firm of the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental the Mental The Me	بر و	de	4 Donation 5 Other Specify 21. Signature of Funeral Service Lice	nsee		22	. Name and A	Address	of Facilit						al Home	
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	Physicia	n	1	23a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line											Between Ons Death	set and
1	Medica	•		Immediate Cause (Final disease	Hyperi	tensive	athero	sclero	otic	car	diov	ascul	ar d	iseas	e	Death	
	,amme	31		or condition resulting in death)	Due to (or as	a consequence	of):										
			ا <u>ه</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):										,
			틾	cause. Enter Underlying Cause (Disease or injury that initiated		a consequence	of):										
	p ·	nsit	Examiner	events resulting in death) Last	Due to (or as												
	executed in and	- tra		X UNPENDED	AMENDE	23a,PI	I,27,	ermE,	g88	88 2/	12/0	)9 TT					
	760, cate be e	burial	Medical	IF FEMALE:	23c. If yes	s, outcome of pre	gnancy						2	23d. Date			ear
	rtifica	as th		23b. Was decedent pregnant in the past 12 months?		birth	2	Fetal death		Ectop	ic pregn	ancy	- 3	Month	'	Day Ye	5ai
	Box 687 e death certificathe attending	or use	Physician	1 Yes 2 No 9 Unknow		gnant at time of c known	5	Other (Spe	сіту)				-			_	
	by the	ched f	畜	Part II. Other significant conditions			resulting in th	ne underlying	cause	given in F	Part I.					the cause of de	
	, P.O.		ক্র	Chronic obstru								1_	Yes 2			bably 4 🗸 Un	
	rds, require been si	2 should b	sted	pyelonephritis									Was an autopsy	24	. Were a prior to	utopsy findings a completion of ca	available ause of
	COF law r has b	s 2 sh	Completed	pyelonephilicis	, piicu	monra							performed Yes 2		death?	es 2	No
	Division of Vital Records, tal or Attending Physician: The law require rs after death.	filled in by the funeral director, page	Š,	25. Was case referred to medical					26.Plac	e of Deat	h (Check	only one)					
	ital sician s cert	irecto	B	examiner?	Hospital: 1	Inpatient 2	ER/Outpat	ient 3 [	OOA	Other <sub>4</sub>	Nurs	ing Home	5 Res	idence 6	Othe	er: Scene	
	of V r Phys ter thi	eral d	1	1 Yes 2 No 27. Manner of Death	28a. Da	ate of Injury onth, Day, Year)	28b. Time	of Injury	28c. Inj	ury at Wo	rk?	28d. Des	cribe how	injury occ	urred		
	on C	_	tion	1 X Natural 5 Pending						Yes 2							0::
	r Atte	n by t	fica	2 Accident Investig 3 Suicide 6 Could n	28e. P	lace of Injury - At	home, farm,	street, factor	y, office	building,	etc.		ation (Stree own, State		mber or R	tural Route Num	ber, City
	Div	Iled is	Certification:	4 Homiside determi	ned (Spec							1					
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	tely fi		29a. Certifier 1 Certifying Physical Concept (Check only one) 2 Medical Examination	ician: To the	best of my knowle	edge, death o	ccurred at th	e time,	date and p	place, ar	nd due to th	e cause(s)	) and man I place, an	ner as sta id due to f	ated. the cause(s)	
	To the within To the	completely	Medical		ner:On the bas and manne	sis of examination or stated.	and/or inves					- actio tinto				onth, Day, Year)	
	F » F	ర	Me	29b. Signature and title of certifier				29		nse numb C.M.E.	01			anuary			
4				/ Carubake	up				0,0	IVI.⊑.				an later y			
_	0-16			30 Name and address of person w	no completed o	cause of death (It	em 23a)	enn Stree	t Rali	timore	MD 21	1201					
2	Part +					ical Examine Registrar's Sign			., ວ	.,,,,,,,,							
		S	tate	31. Date filed (Month, Day, Year)		execution s sign	D. 4	arke									

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

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	•	For State Registrar		State of Ma	aryiani			of Health and of Death	wentai ny	/giene Reg. No	0000	02947
Physicia	ın	1. Decedent's Nam	e (First, Middle, L	ast)	301	4-01/			2. Date of D	Da	, , , , , ,	3. Time of Death
/Medic Examin		4a. Facility Name (	If not institution, gi	ive street and number)	0	, - y	4b. City, T	own, or Location of Dea	TEBR4	- 1	. County of Death	1.401("
~ 4		BON		ours f	tosp	ITAL	If Under 1	SALT MO Year   If Under 24 Hrs				1/A
Funeral Director		<ol> <li>Social Security N</li> <li>212-76-</li> </ol>		Sex 1	e (In yrs. la <b>62</b>	ast birthday) Yrs.		Days Hours Min	. (Month, D	rth la <i>y, Year)</i> 26, 194	Col	nplace (State or Foreign untry)
D		Usual Residence of	f Decedent				-Non		UCL 2	194		Maryland  10d. Inside City Limits
// Aaryla f shov	ō	Maryland	10b. County	N/A	TOC. City	, Town or Loc	alion	Baltimore				1 X Yes 2 No
n the A	Director	10e. Street and Nu		1071			10f. Zip (			10g. Ci	tizen of What Co	untry?
th wit		625 Arche	r Street					21230			U.S.	Α.
er dea items	Funeral	11. Marital Status		12. Was Decedent 8 Armed Forces?		S. 13. V	Vas Decede Yes, specif	nt of Hispanic Origin? ( fy Cuban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	<ol> <li>Race - Amer Black, White</li> </ol>	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a five final Examination to other traumatic event.	þ	3 ☐ Widowed	ied 2 ☐ Married 4 ☐ Divorced	1 □Yes 2 □X If Yes, Give Year or Dates:	40	1	□Yes 2	No Specify:			Specify:	Black
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within iene. <b>than</b>	dwc	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)	life. L	O NOT use	Did not Work			Disa	bled
al Hygi other	Be C	17. Father's Name	(First, Middle, Las	st)					me (First, Middle	e, Maider	Surname)	
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bermit. Depart mport iny inj		21. Signature of A	. ~1	1 1/1	1	\		Address of Facility	oral Canina	D A		
ED = 0 G		23a. Part1. Enter t	the disease, or cor	mplications that caused	the death	Do not ente	130 er the mode	tep Brothers Fun 00 Eutaw Place I of dying, such as cardia	Baltimore, Was or respiratory	id 212 arrest,	17	Approximate
Physician		shock, or hea Immediate Cause disease or condition	art failu <b>r</b> e. List oni (Final	y one cause on each lir $A \leq A$	ne. D / 1/s	2ATI	DX(	7	10 N/A			Interval Between Onset and Death
/Medical		resulting in death)		a. Due to (or as	a consequ	ence of):	014		10/4///			,
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h certi ending	N.	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pre	anancy			23d. Date of deli	very
ne deat the att hed for	Physician/Medica	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4 ☐ Pregnant a 9 ☐ Unknown			Other (spe				Month	Day Year
w requires that the de been signed by the should be detached				contributing to death bu	ut not resu	Iting in the un	derlying ca	use given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
equires en sigi	ed by								1 🗆	Yes 2	□ No 3 □ Pro	obably 4 hnknown
e law re has be	Completed								24a. Was	psy	prior to c	topsy findings available completion of cause of
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ig Phy ter this neral c	ř	27. Manner of Deat		28a. Date of Inju (Month, Da	ry	28b. Time of Injury		c. Injury at Work?	28d. Describe			ary)
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical C	29a. Certifier (Check only one)		aminer: On the basis of	f examinat			it the time, date and place in my opinion, death occ				
o the	Med	29b. Signature and	I title of certifier	and manner sta	neu.		29c.	License number		29d. Da	ate signed (Month	n, Day, Year)
F>F0		1 Ke	Rita	, (K. C	M	na		D0030	355	Fer	bruan	1,2009
6		30. Name and add	ress of person who	completed cause of d	eath (Item	23a) (Type, F	Print)	BOK	SECC	ou r	s for	SPITAL
Sta Registr		31. Date filed (Mon	EB 042	009 32. Registra	ar's Signat	d.	als					

amend #1 Per OHY G888 2/06/09 JH Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:00 AM CeCelia-C. Burdinski Cecelia C. Burdinski 2009 Fehruary 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Battimore, Maryland Agnes Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 220–09–9680 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F MD 87 Yrs 5/16/1921 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantural pages. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State MD Baltimore 1.X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21230 1205 Hull Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2XNo Specify: Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julius Sadowski Rosalia Tyska ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2060 Brandy Avenue, Eldersburg, MD 21784 Ronald W. Burdinski / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/7/2009 4□Donation 5 XOther (Specify) Entombment Cedar Hill Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee Victor Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive theart tailure **Physician** days /Medical Due to (or as a consequence of) Examiner COYUNGN disease years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. YEGVS Obstructive Pulmorar Chronic attending physician and for use as the burial-trar Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ with Respiratory 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertersia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy performe Atrial fibrillation certificate 1 ☐ Yes 2 No Division of Vítal 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide n 24 hours the Funeral Dire Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23496 tehinary 03 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MingHs: Wang, 900 5. M.D Caton Ave. Baltimore, MD 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FFR 0 4 2000 Registrar

09-00928 Scott D. Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cott D. Brown	Registrar	Certificate of		Re	eg. No. 2[	0.09 0.294
Physician ledical Examine				2. Date of Deal Month February	Day Year	3. Time of Death 1011 hrs
~;	4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center		4b. City, Town, or Location of E		4c. County of I	Death
Funeral Director		n yrs. last birthday) 39 Yrs	If Under 1 Year If Under 2  Months Days Hours	8. Date of Bin Min. Dec 2	th(MM/DD/YYYY)	B. Birthplace (State or or oreign New Jersey Country)
any.	Usual Residence of Decedent  10a. State 10b. County 10c.	c. City, Town or Locati	ion			10d. Inside City Limits
<b>*</b>	Maryland Frederick		Union Bridge			1 Yes 2 No
the Maryland t or 28a-f show iffed at once.	10e. Street and Number		10f. Zip Code	10	0g. Citizen of What	•
vith the		printle 13 W/a	21791 as Decedent of Hispanic Origin	2 / Specify Von or No.	U.S.A.	
hours after death with the Maryland inaturals, or items 23a or 28a-f she Examiner must be notified at once		No If Y	es, specify Cuban, Mexican, Portion 1988 2 X No specify:		White, e	American Indian, Black, ltc. White
72 hours after a "natural" al Examine	15. Decedent's Education (Specify only highest grade complete		nt's Usual Occupation (Give kin ost of working life. DO NOT us		16b. Kind of Busin	
more, MD 21215-0036 Pages I and 2 should be filed within 72 rent of Health and Mental Hygiene, wit; If item 27 is marked other than " TO DO Committee.	Elementary/Secondary (0-12) College (1-4 or 5+) 12  17. Father's Name (First, Middle, Last)		technician		HVA	AC .
21215. 21215. Mighe filed Mental Hy marked of	Frank L. Brown, Jr.		18.Mothers	Name (First, Middle, N Bar	bara Bloc	:h
D 21 should: and Mei 7 is ma	19a. Informant's Name/Relationship (Type, Print )  Debbie Brown/ wife		Address (Street and Numbe	r or Rural Route Num	nber, City or Town,	State, Zip Code)
ore, MD 2 es 1 and 2 shoul of Health and M If item 27 is m her traumatic	20a. Method of Disposition	20b. Place of Dispos	Bunker Hill (	Date Date	n Bridge, 20c. Location - Ci	MD 21791 ty or Town, State
Baltimore, bernit, Pages I an Department of Hea Important: If ite	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or oth AllCounty		2/4/2009	Sykesvi	lle. MD
Baltimo permit. Pages Department o Important: I	21. Signature of Funeral Service Licensee	7 22. N	lame and Address of Facility	lartzler F	uneral Ho	me
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insit TX aminor	cause. Enter Underlying Cause (Disease or injury that initiated					
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by the attending physician and ched for use as the burial - transit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Fet	tal death 3 Ectopic pr	egnancy	23d. Date of de Month	ivery Day Year
O. B at the de lby the tached i		not resulting in the u	nderlying cause given in Part I	. 23e. Did to	bacco use contribut	e to the cause of death?
S, P.O.  Lines that the signed by d be detacled by E.				1 Yes	2 No 3	Probably 4 🗸 Unknown
of Vital Records, P.O. Bigging Physician: The law requires that the difference has been signed by the meral director, page 2 should be detached no. To Be Completed by Physician				24a. Was a autops perform	sy prio med? deat	e autopsy findings available to completion of cause of th? Yes 2 No
ician: 7 ician: 7 s certific rector, p	25. Was case referred to medical examiner?	- 7	26.Place of Death (Ch			
n of V ling Phys After thii funeral di	1 Yes 2 No	2 ER/Outpatient 28b. Time of Ir			Residence 6 C	Other:
# _ ` 4   5	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation		1 Yes 2 No			
Division of Vital  Division of Vital To the Hospital or Attending Physician within 24 hours after death To the Funeral Director: After this cen completely filled in by the funeral direct edical Certification: To Be	3 Suicide 6 Could not be determined (Specify)	At home, farm, stree	et, factory, office building, etc.	28f. Location (S or Town, St		r Rural Route Number, City
To the Hos within 24 h To the Fur completely						
A P P P P P P P P P P P P P P P P P P P	and manner stated.  29b. Signature and title of certifier	K	29c. License number			(Month, Day, Year)
	alunt		O.C.M.E.		February 2, 2	009
	30. Name and address of person who completed cause of death Zabiullah Ali, M.D. Assistant Medical Exami		n Street, Baltimore, MD	21201		
State Registra		gnature de la cons	النا			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) TANDARY **Physician** 9:43F M ROBERT WILLIAM BECHTOLD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore Center Towson Joseph Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 □XM 2 □ F 3, 1930 Maryland 78 Auq. Director 218-26-7702 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Havre de Grace Maryland | Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21078 3900 York Dr. Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 35 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: <u>۾</u> 3 Widowed 4 Divorced White Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Shoe Manufacturer other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 7 is marked of traumatic ever Pages 1 and 2 should be Nellie (UNK) (UNK) (UNK) Robert (UNK) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Irene Bechtold / Wife 3900 York Dr., Havre de Grace, MD 21078 other If item or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2-3-09 Towson, Maryland 21. Signature of Funeral Service Licersee, McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC ARREST DUE TO ISCHEMIC HEART /Medical Due to (or as a consequence of) **Examiner** IMMEDIATE DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Exami YEARS ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an certificate ! 2 X No 1 □Yes il or Attending Physician; after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending s after death. I Director: Af in by the full 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 29a. Certifier I 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

the

one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lyl D

res

31. Date filed (Month, Day, Year)

7601 32. Registrar's Signature varke

29c. License number

D 56256

OSLER DRIVE. TOWSON, MARYLAND

29d, Date signed (Month, Day, Year)

# Amend PI line b per MD g888 2/4/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2:00 PM 2009 Shirley January /Medical Temple Brown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNION MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-17-1951 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 □ KF Months Days Hours Min 217-54-2781 Director Md Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene.

Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c City, Town or Location 10a State 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1 ▼ Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 404 N. Kenwood Avenue 21224 Funeral S Α 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black à Specify. 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade N/A Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Morgan Robert Brown 2 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an Patricia Hodge-Gray-5706 Radecke Balto, MD Avenue 21206 Method of Disposition

P Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or concept to the concep Arbutus Memorial 1-26-2009 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Anotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Myocardial infarction Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has page 2 autopsy performed Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation ours after death, neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0061180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulhmore, Maryland Elliot Share East 201 D.01 University

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Pagistrar's Signature

State of Maryland / Department of Health and Mental Hygien 0 0 02952 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Nicholas Valentine Beckel February 3, 2009 3:45 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Living Nursing Home Westminster Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 10, 1 Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2 F 81 Yrs. Director 165-22-2439 1927 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show nit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla admental Hygiene. admental Hygiene. ortent: if item 27 is marked other than "nature", or items 23a or 28a-1 show in jury or other treumatic event, it is Wedical Examiner must be notified at injury or other treumatic event. Funeral Director 1 ☐ Yes 2\ No Maryland Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4250 Flail Drive 21074 of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: Specify: 3XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Bander U.S. Steel 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) John Joseph Beckel Catherine Schlerth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Koren (Daughter) 4250 Flail Drive, Hampstead, Maryland 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 4, 1 ☐ Burial 2XXX remation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) Metro Crematory 2009 Catonsville, Maryland 21 Signature of Fury Service L 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demer **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Hospital or Attending Physicien: The law requires that the death certiticate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 00 Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2XNo 2 💢 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: tilled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 2 28 amoly D 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIXA 349 Malus DR, Martminter M21157 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 02953 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charline S. Butler February 2009 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10500 Rockville Pike #1501 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 352-10-8311 89 Director Oct. 6, 1919 Colorado Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extra in an 15s or refilled. Director 1 ☐ Yes 2 X No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10500 Rockville Pike #1501 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Savage Agnes Flynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Butler/Son 2675 Leslie Road, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery crematory or other place)
Gate of Heaven
Mausoleum 20a, Method of Disposition February 7, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ★ Other (Specify Entomoment 2009 Silver Spring, Maryland 21. Signature of Juneral Service Licen Robert A. Pumphrey Funeral Home/Bethes a-Chevy 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 7557 Wisconsin Ave., Bethesda, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer to Lung month /Medical Due to (or as a consequence of): Examiner Unknown Primary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner This to (or as a consequence of) The law requires that the death certificate be executed and trai Due to (or as a consequence of): physician a sthe burial-Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼ No 5 ☐ Other (specify) Day Year signed by the a I be detached f P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page 1 ☐ Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fur 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onl To the 1 within 2 To the 1 26b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32610 February 3, 2009 Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. McNamara, M.D. 19735 Germantown Road #100, Germantown, Maryland 20874 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

		1 For State Registrar	State of Maryl	and / Depa <i>Cer</i>	rtment of H	lealth and M Death	lental Hyg	iene g. No.	09 02954
Phys	ician	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	dical	Thomas Kim 4a. Facility Name (If not institution, give	BANN street and number)		4b. City. Town, or	Location of Death	02	01 4c. Coun	of 10. PM
Exam	liller	Bultimore Rehab. E.		Cenka	Ba	lhmon			NIA
Funer Directo		5. Social Security Number 6. Sec. 226–60–8515	7. Age (In)	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUG 11,	1945	9. Birthplace (State or Foreign Country) <b>Maryland</b>
land ow	(i	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Mary a-f sh	cto	MD Baltimore	Ce	ockeysvi	lle				1 □Yes 2X No
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after d or iten	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 □ No	1	Yes, specify Cubar ☐Yes 2 <b>X</b> No	n, Mexican, Puerto  Specify:	Rican, etc.)	BI	ack, White, etc.
5-UUS6 72 hours afi natural", or fical Evami	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:V1e	tnam					White
nin 72 nin 72 nin 72 nin "nat	plete	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired,	during most of worki	ing	6D. Kind of	Business/Industry
Z I Z ed with ygiene ygiene ier tha	Completed		College (1-4or 5+)	Mechan	ic			Autom	otive
Dallilliore, INIATYIAIIQ ZIZIO-UU3O permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, I'm Nedical Evantine and the natified at	Be	17. Father's Name (First, Middle, Last)  Marlin Brown				18. Mother's Name		laiden Surna	ume)
should nd Me mark mark	မ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailin				City or Tow	n, State, Zip Code)
y IVIC		Nancy B. Daramus/s				sville Pi			
Dore Jes 1 a t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F			natory or other place	e)	1		- City or Town, State
Dallillor Dermit. Pages Department of mportant: If it		4 ☐ Donation 5 ☐ Other (Specify)	M			Inc. 2/2/			ore, MD
Depa Depa Impo	- SDCG	21. Signature of Funeral Service License	C. Todd Dr	ing C	remation 99 Freder	ss of Facility Society rick Rd B	of Maryl	and, Ir	nc 21228
		23a. Part 1. Enter the disease, of complishock, or heart failure. List only or	cations that caused the die cause on each line.	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death 3 [	Ectopic pregnancy	1			ate of delivery Month Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 □	Other (specify)				Day Teal
w requires that the desired should be detached	by Ph	Part II. Other significant conditions cor	tributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use co	ntribute to the cause of death?
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e law r has b	Completed						24a. Was an autopsy	, I	. Were autopsy findings available prior to completion of cause of
or Attending Physician: The law after death.  Director: After this certificate has in by the funeral director, page 2	S O	25. Was case referred to medical						⊡M₀	death? 1 □ Yes 2 □ No
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ding Photon of the control of the co	L:uo	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how		
thend death.	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury A	t home farm stre		res 2□No	29f Location /Str	aat and Nun	nber or Rural Route Number,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical C	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my	knowledge, death nination and/or inv	occurred at the time time stigation, in my op-	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and r te and place	manner as stated.
To the within 2 To the complex	Med		and manner stated.		29c. License	number	29	d. Date sign	ed (Month, Day, Year)
		I had a	~		15	2739		2/11	05
3	-	30. Name and address of person who co	mpleted cause of death (I	tem 23a) (Type, F	Print)		2: 1	- · · ·	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Si	nature 3	900 Lock	LWEN	Blvd.	Butt	mre, 4d 2/211
Regis	strar	30. Name and address of person who con Baltana F. Jan Jan. 31. Date filed (Month, Day, Year) FEB 0 4 2009	Denne B	gare					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 59 AM 02 09 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death Examiner tospital Somanton Baltimore Baltmore 8. Date of Birth Month Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Director death with the Maryland show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if e Medical Examinations to notified at once. **Funeral Director** es 2 □ No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1N27es 2 ☐ No 1 7es 2 ☐ Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced as Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use intired College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be ٥ issa 19a. Informant's Name/Relationship (Type. Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Burial 2 Cremation 3 R
4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funer of rvice I censee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ma conce disease or condition resulting in death) /Medical Due to (or as a conse runce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 d Yes 2 □ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 400 certificate has 2 40 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Richard Park, MD 5601 Loch Raven Blvd., Baltmare, MD 21239

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29 of Maryland / Department of John and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Doris V. Broadfoot January 12, /Medical 2009 1:15 PM N 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2∏F Months Days Hours Min. Director 212-07-0651 91 Apr 9, 1917 Maryland Usual Residence of Decedent death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be realised at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane CR 215 21228 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 □Yes 2√2 No Specify 3 ♥ Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John R. Sakers P Virginia Welton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gray/daughter 10209 Green Clover Drive Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatura | Euneral Service Licens e 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Cause Cause). Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physician/Medical the certificate has been signed by the attending rivector, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 1 □Yes 5 ☐ Other (specify) Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **N**o 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Certification: To 1☐ Yes 2☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours after death. Pruneral Director: A investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choice In Catonoville MD Maiden 31. Date (ile

DHMH 17 Rev 1/2001

State

Registrar

Month, Day,-Year)

04

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last	)						
Examiner		lola C	rawford			2. Date of De Month JAN	Day Year	
Funeral	4a. Facility Name (If not institution, give	ong Green Center				ltimore	4c. County of Dea	N/A
Director	5. Social Security Number 6. Se 1	] M 2□√F		f Under 1 Year Months Days		8. Date of Biri (Month, Da	th 9. Bir 9. 5, 1922	thplace (State or Foreign buntry) So. Carolina
Aaryland f show	10a. State 10b. County	10c. Cit	ty, Town or Locat	ion	Baltimore			10d. Inside City Limits 1 □ <b>X</b> es 2 □ No
a or 28a-f st to be notified the Director	10e. Street and Number  1159 Sherwood Avenu			10f. Zip Code	21239		10g. Citizen of What Co	ountry?
72 hours after death with the Maryland "natural" or items 23a or 28a-f show adral Examiner must be notified at leted by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Woowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		s Decedent of es, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
within sne. than '	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	(Give kin	nt's Usual Occu nd of work done NOT use retire	during most of work	king	16b. Kind of Business So. Carolina	/Industry a School System
tal H d oth even	17. Father's Name (First, Middle, Last)	V n a v v m				ne (First, Middle,	, Maiden Surname) Ida Hunter	
12 should be h and Mental 7 is marked of traumatic ever	19a. Informant's Name/Relationship (7)	Known vpe. Print)	1				er, City or Town, State,	Zip Code)
permit. Pages 1 and 2 Department of Health is Important: If Item 27 is any Injury or other tra once.	Sally Woodard  20a. Method of Disposition  1 Borial 2 Cremation 3 4 Donation 5 Other (Specify  21. Signal Function Service Licens	Removal from State	Place of Dispositi cemetery, cremate Mt.	on (Name of tory or other plan Zion Cem lame and Addi	ace)	01/31/09		Town, State
hysician and by site burial-transit as the burial-transit edical Examiner	23a. Part1. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. DEMER Due to (or as a conseq	v 7 , A quence of): 57, v 6	the mode of dy	ART	or respiratory a	rrest,	Approximate Interval Between Onset and Death M GNAT
attending for use as cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3 □E	ctopic pregnan other (s <i>pecify</i> )	су	-	23d. Date of de Month	llivery Day Year
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this ald	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA ]		lome 5 ☐ Resi	one) idence 6 □Other (Spe how injury occurred	əcify)
r Atten ter deat irector: by the tifical		(Month, Day Year)	Injury nome, farm, stree		☐ Yes 2 ☐ No		Street and Number or F	Pural Route Number,
To the Hospital of within 24 hours aff To the Funeral D completely filled in Medical Cert		ysician: To the best of my kno niner: On the basis of examination and manner stated.						
To the comple	29b. Signature and title of certifier				nse number		29d. Date signed (Mon	
3	30. Name and address of person who of Shake NM	completed cause of death (iter	m 23a) (Type, Pri	DO int)	05315	TIAC	JAN 2 OM C	4 2009 17E113

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 **Physician** Ethel C. Council February 2009 10:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3300 Benson Avenue, Apt. Baltimore n/a Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Sept 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days 1 □ M 2 🕏 F Months Hours Min. 214-24-6460 102 1906 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Maryland n/a Baltimore Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3300 Benson Avenue, Apt. 401 21227 United States Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- " any injury or other traumatic events." 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) unk. Sturm 18. Mother's Name (First, Middle, Maiden Surname) Be unk. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Council, Sr. / Son 334 Utah Road, Stevensville, Maryland 21666 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gds. 2/4/2009 Sykesville, Maryland 4 ☐ Docation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresshock, or heart failure. List only one cause on each line. Immediate Cause (Final leutricular ardiac trom 1 arres. Minuste disease or condition resulting in death) a chy cust Due to (or as a consequence of): leurs Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) lars Chronic that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Ö σ. Records, of Vital Division

burial-transi attending physician for use as the burial pe signed by the a d be detached f should been page 2 s has certificate

**Funeral** 

Director

28a-f show

death

7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at

Physician

/Medical

Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical

29a. Certifier

State Registrar DOUGIN

29b. Signature and title of certifie

MD into

29c. License number D51018

1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person

MD

and manner stated.

completed cause of death (Item 23a) (Type, Print) Benson Ave ..

3421

32. Registrar's Signature 31. Date filed (Month, Day, Year)

parle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., 8888,02/10/09dhb
Amend Items 23e,24a,23y26,27,29a,360 per dr., 8888,02704/09dhb For Amend Items 238,24a,25,20,21,25a,50 per un., State Registrar Amend \$17818 Per Inf G889 3/20/16/2016 Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 25, 200<sup>year</sup> Thomas Edward Clark 2:40 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 X M 2 □ F Months 226-68-9102 59 Director Jan 7, 1950 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director MD Anne Arundel Laure1 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 Elkton South 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mentalet Hygiene. In the ZT Is marked other than "natural" or ite iny or other traumatic event, Its Nexter Exercise. Armed Forces:
1 XYes 2 No
If Yes, Give
Year or Dates: 168-71 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify white <u>გ</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Pratt
David Prain Clark Be Elene Louise Graham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Clark/spouse 236 Elkton South Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Si nature di Funeral Service I densee NONALO Wade Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) cardiogenic shock Physician /Medical Due to (or as a consequence of) Examiner myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sella consequence offi-Examine bilateral pneumonia burial-tra Due to (or as a consequence of): Box 68760. physician The law requires that the death certificate be Physician/Medical the SS attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No ned by the o 9 Unknown 9 Dlnknown cate has been signed by page 2 should be detach ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 pulmonary hemmorhage, adult respiratory distress 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown Completed Diabetis Mellitus, Type 2; Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an syndrome, morbid obesity autopsy orme**d**? 2 🗖 No certificate Sleep Apnea, Hypertension 1 ☐ Yes of Vital the Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 [] Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063639 Januvary MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pothu Raju Nagabhyru, MD, 10 Center Dr. 10/4-5722, Bethesda, MD 20892 31. Date filed (Month, Day, Year)\_ 32 Registrar's Signature State barke Registrar

50

Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Madicial Examination and injury or other traumatic event, the Madicial Examination and once.

Maryland 21215-0036 od & hein

Baltimore,

**Physician** /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

C.

Evelyn

	. For		State of Ma	arylan	d / De	partme	ent of H	lealth and I	Mental Hy	/gien	eanno	02960
	State Registrar				C	Certifica	ate of	Death		Reg. No	2003	02300
	1. Decedent's Name	e (First, Middle, La	st)						2. Date of D		Vaar	3. Time of Death
ın I	Evelyn	R Cough]	منا						Month	30	ay Year 2009	1106 A M
ai er	4a. Facility Name (II	f not institution, giv	e street and number)			4b. Cit	y, Town, o	Location of Death	1	40	. County of Dea	th
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	5. Social Security N	umber 6. S	Sex 7. Ag	e (In yrs.	last birtho	Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Jay, Year	9. Bir	thplace (State or Foreign ountry)
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eral	1315 Chesa	CO AVEILUE	40 Mac Decedent	Consin II	c	10 Man Day		lianania Origina (C.	nacify Vac or N			nion testas
Ë	11. Marital Status	0 1 1 1 1 1 1 1	12. Was Decedent Armed Forces? 1 Tyes 2 X		5.	If Yes, sp	ecify Cuba	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
J yc	3 ★ Widowed	ed 2 Married	If Yes, Give Year or Dates:	140		1 ☐ Yes	2 <b>XX</b> No	Specify:			Specify: Wh:	ita
ed	5 = 11101100	15. Decedent's Ed	1		16a. D	ecedent's Us	sual Occur	ation		16b. F	(ind of Business	
plet		ify only highest gra	ade completed)		(0	Give kind of vife. DO NOT	vork done	during most of wor	king			
Completed by Funeral Director	Elementary/Second 12	ndary (0-12)	College (1-4or t	o+)	Seco	retary				Pa	per Compar	ny
Be C	17. Father's Name (	(First, Middle, Last,	)					18. Mother's Nam	ne (First, Middle	e, Maidei	n Surname)	
To B	Jacob Bre	nner						Ruth Roma	ans			
_	19a. Informant's Na	ame/Relationship (	Type. Print)		19b. N	lailing Addre	ess (Street	and Number or Ru	ıral Route Num	ber, City	or Town, State,	Zip Code)
	Thomas B	Coughlin (S	Son)		1008	30 Maple	ewood I	Orive Ellic	cott City	, Mar	ryland 210	042
	20a. Method of Disp			20b. P	Place of D	isposition (N	lame of	20)	Date	20c. L	ocation - City or	Town, State
		☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State (v)	i _		n Churd	_	February	2 2009	Bal	timore,Ma	rvland
	21. Şigqatylre of Fu				OOOOPI			ss of Facility eral Home I		1	J,	-
	Mart	0. Do	sho ()					eral Home l Road Balti		m (lon	4 21226	
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	Immediate Cause (	(Final			C 0.44	4	-55 A.S	W. 0. 1	0.4210	Lah	acliui	Onset and Death
	disease or condition resulting in death)	on a	a. Preumor	a consequ	uence of):	mani i	y at	ganea	Singue	200	MI (LLLL)	
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ner	Sequentially list con if any, leading to in- cause. Enter Unde Cause (Disease or	nditions,	Due to (or as	ā Coliseqi	dence of)							
Examiner	that initiated events	3	c.									
Ë	resulting in death) I	Last	Due to (or as	a conseq	uence of)	:						
dical			<b>d</b>									
Ned	IF FEMALE:											
an/l	23b. Was decedent		23c. If yes, outcome 1 ☐ Live birth			3 ☐ Ectopi	c pregnanc	v		1	23d. Date of de	
sici	in the past 12	No	4 ☐ Pregnant a			5 ☐ Other		<u></u>			Month	Day Year
Completed by Physician/Me	9 Unknown								00- 014	A - I		
by	Part II. Other signif	ricant conditions (	contributing to death b	out not res	utting in tr	ne underlyin	g cause giv	en in Part I.			-	o the cause of death?
ted									1L	Yes 2	PINO 3 P	robabiy 4 ☐ Unknown
ple									24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
Son									per 1 □ Yes	formed?	_ death?	s 2 No
Be (	25. Was case refer examiner?	red to medical					Lete	26. Place of Dea				
	1 Yes 2 ☑	No	Hospital: 1 Inpati	ent 2	ER/Outp	atient 3 🗍	DOA Oth	er: 4 Nursing H	lome 5 Res	sidence	6 ☐Other (Spe	ecify)
.:.o	27, Manner of Deat	h 5 ⊟ Pending	28a. Date of Inju (Month, Da	ury ay, Year)	28b. Tin Inju		28c. Injui Wor	y at k?	28d. Describe	how inju	iry occurred	
Sati	2 Accident	investigation				M	1 🗆	Yes 2 □No				
rtifi	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined		ury - At ho c. <i>(Specil</i>	ome, farm fy)	, street, fact	ory, office		28f. Location City or To			ural Route Number,
Ce			1									
Medical Certification: To	29a. Certifier (Check only	1   Certifying Pl 2   ■ Medical Example	hysiclan: To the best miner: On the basis	of examina	owledge, o	death occurr or investigat	ed at the ti	me, date and place opinion, death occu	e, and due to thurred at the time	e cause( e, date ar	s) and manner and place, and du	s stated. e to the cause(s)
Med	one)		and manner st	ated.								
2	29b. Signature and	rtine of certifier				1 2	29c. Licens	e number	- 1	29d. D.	ate signed (Mon	th. Dav. Year)

State

Registrar

30. Name and address of pg

SENTA HULL ENS 9000
31. Date filed (Month, Dal Val)

4 2009

DHMH 17 Rev 1/2001

M.D.

to completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

FRANKLI

D62573

DR

Sauare

1-30-2009

Balto md

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death
 Month **Physician** January 28,2009 Wanda Ann Cooke 7:13P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5015 Forge Haven Drive Perry Hall Balto. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Social Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 9, 1956 9. Birthplace (State or Foreign 1 □ M 2 🖔 F Director 219-58-7447 Yrs. 52 Maryland Usual Residence of Decedent 10a. State 28a-f show 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Experiment near be notified at 10d. Inside City Limits Director Md. Balto. 1 ☐ Yes 2 No Perry Hall 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 10g. Citizen of What Country? 5015 Forge Haven Drive Funeral 21128 US 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married Married Black, White, etc. Baltimore, Maryland 21215-0036 \$ 1 □Yes 2X No If Yes. Give White 3 Widowed 4 Divorced Specify: Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 7 Masters Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Torrieri Rosario Maranto 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 siment of Health an 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Charles R. Cooke</u> Spouse 5015 Forge Haven Dr. Perry Hall, Md. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. ò ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Dulaney Valley 2-2-2009 Timonium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Stefamo \ cue 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastrutic bast cance 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be exerted attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ed by the a 5 ☐ Other (specify) Month Day Year 9 Unknown 9 ☐ Unknowh signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 23e. Did tobacco use contribute to the cause of death? Completed been s 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ ₩o has le 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 certificate ha autopsy performe 1 □Yes 2 ☑No tor: After this certifiinthe funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 | Yes 2 | No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 28d. Describe how injury occurred 5 Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2 29b. Signature and title of certifier 2 29c. License number 040850 MD Vanuary 29, 200 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Ottaviano 9103 Franklin Square or Baltimai MD 21237 31. Date filed (Month, Day, Year) State 32. Registrar's Signature FEB 0 4 2009 Registrar Darke

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 29, 2009 ear 9:40P January Waldo R. DeLeon Colon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto. Towson Gilchrist 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Date of Birth (Month, Day, Year) 1**X** M 2 □ F Months Days Hours Min NewYork January 16,1964 Director 45 582-25-7413 Usual Residence of Decedent 10b. County Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
say injury or other traumatic event, it a Medical Evantia without be notified at
once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Parkville Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral 42 Bourbon Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Hispanic X□Yes 2□No Specify: Puerto Rico 2 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felicidad Colon Miguel A. DeLeon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 42 Bourbon Ct. Parkville, Md. 21234 Sharon O'Dell Creed Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-2-2009 Bayview Balto, City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home L 9705 Belair Rd. Nottingham , Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final untangous Broterial Physician disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner Stage Since antially list of offices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify). ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 PINO 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specif 1 Yes 2 No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

P.O. Box 68760. January of Vital Records. To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t completely filled in by the funera Division

Baltimore, Maryland 21215-0036

12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na

Pages 1 and 2 srtment of Health a

burial-transit

the attending physician hed for use as the burial

n signed by the a

After this certificate has been funeral director, page 2 should

filled in by the funeral

29a. Certifier

State Registrar

Medical

29b. Signature and title of certifie

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N.C

and manner stated

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 02963 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2, 3. Time of Death **Physician** Judith Pia Captain February 2009 8:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9516 Milstead Drive Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months Days Hours Min 17, Director 225-04-6084 44 Nov. 1964 Tennessee Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Extending and Director 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9516 Milstead Drive 20817 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No ģ Specify Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be → pe t George A. Captain Clara Sue Williams ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra once. 5417 York Lane, Bethesda, Maryland Jill F. Captain/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State February 4 Donation 5 Other (Specify) 5, Metropolitan Crematory 2009 Alexandria, Virginia 21. Signature of Funeral Service Licers a 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda- Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Ulllerin M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ovarian Cancer disease or condition resulting in death) 20 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran that initiated event resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐Yes 2 ☐ No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital 1⊠Yes 2□No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

10 V

State Registrar 29b. Signature and title of certifie

Bruce Kressel,

much

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D.

29c. License number

D0023600

29d. Date signed (Month, Day, Year)

February 2, 2009

20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 304 2009 Juanita F. F. Cheeks January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown | FUnder 1 Year | | If Under 24 H Balto Seasons Hospice Northwest 8. Date of Birth (Month, Day, Year) 8-22-1946 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign **Funeral** 1 M 2 X Months Days Hours Min Director MD 213-52-2220 62 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f showevent, It would be a mainted at Director MD N/A 1 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Orleans Street 21231 s snould be filed within 72 hours after death v h and Mental Hygiene. Funeral U S A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 □Yes 2√1No Specify Specify: Black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) J. H. 12th grade Outreach Worker N/A17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be William R. Flanagn permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 1s marked any Injury or other traumatic evance. Rosalee Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cheeks-Husband 2120 Orleans Street Balto, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Greenmount 2-3-2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCKETIC CARCINOMA TERMINAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ne Due to for as a consequence off The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): physician a Physician/Medical signed by the aftending | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No cate has page 2 s autopsy this certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the vithin 24 hours after use....
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

O. Box 68760. ď. Records. of Vital To the Hospital or Attending Physician: Division

Baltimore, Maryland 21215-0036

Y

State Registrar

address of person who completed cause of death (Item 23a) (Type, Print) 2835 Ton 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature assame.

and manner stated

Smith Avenue Suk 203 Baltimore MD 21208

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 5:45 AM M /Medical Bettie Margaret Collins February 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Stella Marís Hospice Raltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 M F 68 Director 244-52-6875 12/12/1940 NC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified Director 1 ☐ Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ò 23a Funeral 21222 98 Avalon Avenue or items, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces'
1 Yes 2 If Yes, Give
Year or Dates: Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 2 110 21215-0036 1 ☐Yes 2 ☐NO Specify: <u>ک</u> 3 Widowed 4 Divorced "natural" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other Clerical 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ဥ Henry Collins Blease Kersey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. Health 294 Attenborough Drive Apt. Virgil R. Miller/Son <u>101 Rosedale, MD 21237</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 ment of F Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 3 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Garder 2009 Middle River, Maryland 22. Name and Address of Facili@AFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 8717 Green Pastures Dr. Balto, MD, 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence off requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 Other (specify) ed by the a detached for ☐Yes 2**X** No 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy perform Vital 2**X** No 2 □ No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \times$  Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 1 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) X Nurse Practitationer stated. within 2 To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) ZOU 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

5:45

EBRUARY

BETTIE COLLINS

State Registrar

Name and addiress of perso

31. Date filed (Month, Day, Year)

FEB 0 4 2009

P.O. Box 68760,

Division of Vital Records,

ong

ho completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

415

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \begin{align\*} \be 02967 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JÄNUARY 30 IRENE COHEN 2009 5:40 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 04/14/1912 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F MD 216-05-7995 96 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3211 CLARKS LANE, #404 21215 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married natural", or 1 ☐ Yes 2 💢 No Specify. Specify: WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY SH0E ulth and Mental Hygie 27 Is marked other i r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be **JACOB** SILVERMAN ROSA GOLDBERG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any injury or other trauonce. 1826 COURTYARD CIRCLE, BALTIMORE, MD 21208 WENDY COPLAN GOULD/GREAT-NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State B'NAI ISRAEL CONG. 02/02/2009 | BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician month Metastano /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and al-transit Due to (or as a consequence of): physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 Dio 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy certificate ha death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Augursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural
Accident

the Hospital or Attending Physician: The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, Director:

Baltimore, Maryland 21215-0036

5 Pending investigation

6 ☐ Could not be

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes 2 🗆 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Date filed (Month, Day, Year)

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32. Registrar's Signatu

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Registrar
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31. Date filed (Month, Day, Year)

32. Registrar's Signature

	1	For State Registrar	State of Ma	ryland /	_	rtment of F tificate of		/lental Hy	giene Reg. No. 2	009	02969
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Examine	er	4a. Facility Name (If not institution, give	Hospipi 1	(enter			r Location of Death	V	С	ty of Death	\
Funeral Director		5. Social Security Number 6. S 229-14-5989 Usual Residence of Decedent	ex 7. Age SM 2□F 8	) (In yrs. last b	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D Pec 26	1 <sup>92</sup> 1	Vi.T	place (State or Foreign ntry) ginia
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urs a	by Funeral	11. Marital Status  1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2¥ N If Yes, Give Year or Dates:		1	Vas Decedent of H FYes, specify Cub □Yes 2□No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ace - Ameri lack, White, Wh cify:	
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3		30. Name and address of person who	completed cause of d	eath (Item 23a	a) (Type,	Print) Mije 307	westmi	nsper	MO Z	1157	
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of Vital Records, ng Physician: The law requir wher this certificate has been s meral director, page 2 should 1	Completed					perf 1 <b>✓</b> Yes	ormed? dea	
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of Villing Physi After this funeral dir	on: To	27. Manner of Death 28a. Date of Injury (Monthly Ref. Year)	28b. Time of 1133 hrs		njury at Work?  Yes 2 ✔ No		how injury occurred struck by vehic	le
Division fal or Attendir rs after death. al Director: A	Certification:	2 ✓ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, stre	eet, factory, offic		or Town.	State)	or Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined (Specify) Major   29a. Certifier 1 Certifying Physician: To the best of my kno	owledge, death occu	urred at the time	, date and place, a	S/B New Ha	mpshire Avenue, I use(s) and manner as	stated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examina and manner stated.	ation and/or investiga	ation, in my opin	nion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)  (Month, Day, Year)
	≥	29b, Signature and title of ceptifier  Anticols			C.M.E.		February 2, 2	
41		Name and address of person who completed cause of death Laron Locke MD. Assistant Medical Exami		n Street, Ba	Itimore, MD 2	1201		
Regis	State	31. Date filed (Month, Day, Year) 32 Registrar's S	F+0	Rad				
Regi	-41621	THE STANGE POVER	- 1					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TTEM#5perFH G888.2/6/09 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 755 AM **Physician** Patricia Demen € OB 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 □ M 2 🗓 F Washington, DC May 26, 1941 Director 67 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exercitor must be notified at 1 □Yes 2 XXIo Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 United States 2408 Colston Drive Unit 102 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. within 72 hours after 1 □Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Ş Q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.

is marked other than " Elementary/Secondary (0-12) 12 College (1-4or 5+) Newspaper Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maxine Powell Daniel Pilkington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 1608 East West Hwy. Apt 044 Silver Spring, MD 20910 James D. Dement (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan 31, Department of Important; If it any injury or conce. 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 2009 Beltsville, MD Chesapeake Crematory 5 ☐ Other (Specify) 4 ☐ Donation 22. Name and Address of Facility <sup>2. Name and Address of Facility</sup> Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, MD 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopulmonory Physician immediate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 6 Week weg Corner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 0 9 Unknown been signed by should be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Lycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 15010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIH, 10 Center Dr. Bldg.10,4-3940, Bethesda, MD 20892-1201 David S. Schrump M.D. 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month

JANUARY 46. County of Death **Physician** 30PM EDWARDS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSPITAL RANDALLETOWN **HOICHWEST** BALTIMORE MD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 12 21 195 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2□ F 215 - 70 - 740 51 Director So. Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f sho event, my fredient Examinating 1 □ **½**es 2 □ No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3041 Bero Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, it is it is in a number. 21227 U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Odd Jobs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Porter Mary Edwards ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3041 Bero Road Baltimore, Maryland 21227 Leola Atkinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/03/09 Catonsville, Maryland Metro Crematory, Inc. 21. Signatule of Funeral Service 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 or complications that caused the deata. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart fail re. List only one cause on each line. Immediate Cause (Find PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) IMMUNODEFICIENCY SYNDROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DIAGETES MELLITUS TYPE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 1 ☐ Yes 1 XYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ Certification: 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of of

Registrar
DHMH 17 Rev 1/2001

State

Bark

ORD BALTIMORE DR. #110 BALTIMORE, MD 21244

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3100 L

32. Registrar's Signature

DEPESTRE

AYNOLD

31. Date filed (Month, Day, Year)

#18 Per FH G888 2/04/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 02974 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31,2009 Month **Physician** Jan. 5:10A M Thomas P. Easter, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore n/a 8. Date of Birth (Month, Day, Year)
July 10, 9. Birthplace (State or Foreign Country)
35 VA. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Year) Hours 1 M 2 □ F Months Days Min. 231 42 9791 1935 73 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examine in ast be in affiled at once. 1 ∏Yes 2 ☐ No Director MD n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 201 N. Washington St. 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ¥o Specify: Specify: BLACK <u>≽</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) laborer Moving and Storage 12th18. Mother's Name (First, Middle, Maiden Surname)

Ethel Craves 17. Father's Name (First, Middle, Last) Be Clarence Easter Ethel ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Easter (daughter) 19 N. Highland Ave. Balto, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Contact of ☐ Cother (Specify) Trinity Cemetery | 2/5/09 Baltimore, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Ε. Preston St. Balto, Md. Approximate Interval Between On et and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last mainfieldy first econditions (on as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) □Yes 2□No P.0. To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signatul ess of person who completed cause of death (Irem 23a) (Type, Print) 4000 Samar 31. Date filed (Month, Day, State Registrar

23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANEMIA

9 Unknown

RENAL INSUFFICIENCY CHRONIC

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No

Reg. No.

28

2009

4c. County of Death

10g. Citizen of What Country?

Specify:

Own Home

Spera

16b. Kind of Business/Industry

20c. Location - City or Town, State

Baltimore, MD

USA

Race - American Indian, Black, White, etc.

White

N/A

1345 PM

9. Birthplace (State or Foreign Country) **Italy** 

10d. Inside City Limits

Approximate Interval Between Onset and Death

UNKNOWN

UN KNOWN

UN KNOWN

UN KNOWN

1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 No

GOUT

23b. Was decedent pregnant

1 □Yes 2 □ No

9 Unknown

ģ

Completed

Be

Certification: To

Medical

certificate

in the past 12 months?

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

3 🗆 Ectopic pregnancy

5 ☐ Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

27. Manner of Death 5 Pending investigation 1 Natural 2 Accident

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Suicide 4 Homicide

28d. Describe how injury occurred

(Check only one) 29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

ATTENDINS

00056948

2009 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 ARMORT PLACE SUITE 3H. BALTIMONE MO 2120/ TANSINDA 31. Date filed (Month, Day, Year)

State Registrar

Q

32. Registrar's Signature FEB 0 4 2009

Records,

**Division of Vital** EDWARDS,

Hospital or Attending

death.

within 24 hours after death To the Funeral Director: completely filled in by the

			Please Type or Print in Black Inc.  State of Maryland / Department State  Amend Item 26 per verb., g888	-	_	02976
ı	Physicia		1. Decedent's Name (First, Middle, Last)  Ozella Ford	2. Date Monti Jan	n Day Year	3. Time of Death 7:20P. M
in	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
n de			8510 Stevenswood Road	Windsor Mill	Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   (Months   Months   Birth 9. Bir h, Day, Year) C	thplace (State or Foreign ountry)	
	Director		216-30-7106	Aug.	13, 1933	S.Carolina
	yland now		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	a-f sh	ctor	Maryland Baltimore Randalls	stown		1 □Yes 2√□No
	or 28	Dire	10e. Stree and Number	10f. Zip Code	10g, Citizen of What C	ountry?
	be filed within 72 hours after death with the Maryland tial Hyglene. 8d other than "natural", or items 23a or 28a-f show event, the Medical Evariner must be notified at	Completed by Funeral Director	5109 Old Court Road Apt.113	21133	USA	
	items	in in	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Nas Decedent of Hispanic Origin? (Specify Yes of Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - Am Black, Whit	
36	ırs aft Il", or Xami	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 □Yes 2 및No Specify:	Specify: B	lack
0-0	2 hou	ted		dent's Usual Occupation kind of work done during most of working	16b. Kind of Business	/Industry
21		nple	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give life. L	OO NOT use retired)		
121	filed wi Hygier other th	ပ်		ine Operator		orporation
and	be fill	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	•	
Z	should be filed within and Mental Hygiene. s marked other than umatic event, the M	은	Roger Smith  19a. Informant's Name/Relationship (Type. Print)  19b. Mailir	Lillie Sing		Zin Code 2 1 2 4 4
Baltimore, Maryland 21215-0036	. 00 00 =		Delores Ford-Edwards/Daughter	8510 Stevenswood R		, ,
re,	s 1 and 2 of Health item 27 I		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date natory or other place)	20c. Location - City or	Town, State
E	Pages nent of I ant: If ite		Magnetial 2 □ Cremation 3 □ Removal from State King mer	morial Park 1/23/09	Woodlawn, N	Maryland
alti	permit. Pages Department of Important: If it any Injury or o		21. Signature of Foneral Service Licensee 22	. Name and Address of Facility hat man-	Harris Fune	eral Home
_	89728	2		240 Reisterstown Ro		Md 21215
			23a Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line,	er the mode of dying, such as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
6.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	acer		
Ŧ	Examiner		Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.		-	
,09	te be executed /sician and e burial-transit	Ë	resulting in death) Last Due to (or as a consequence of):			
	cate b	dical	d			
Box 687	certifi Iding	Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of de	divore
B	death atter	ciar		Ectopic pregnancy Other (specify)	Month	Day Year
P.O.	t the c by the achec	hysi	9 Unknown			
	es tha igned oe del	by P	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I. 23e.	Did tobacco use contribute t	
ord	een s	ted	end tage renal feither		1 ☐ Yes 2 1 No 3 ☐ F	robably 4 Unknown
Division of Vital Records,	law i has b e 2 sh	Completed			autopsy 🦯   prior to	utopsy findings available completion of cause of
a F	n: The licate r. pag			1 🗆 )	performed? death? res 2 No 1 □ Ye	s 2 No
Ζ̈Ϊ	sicial certii irecto	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death (Check of		Daughter's
of	a Phy er this eral d	n: To	27. Many er of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. Desc	ribe how injury occurred	Residence
ion	ath. r: Aft	atio	1  Natural 5  Pending (Month, Day, Year) Injury 2  Accident investigation	Work? M 1 □Yes 2 □No		
Vis	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Locat	ion (Street and Number or Fi or Town, State)	ural Route Number,
۵	ital o Ins aft ral Di					
\	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deatl to the best of examination and/or in and manner stated.	n occurred at the time, date and place, and due t vestigation, in my opinion, death occurred at the	o the cause(s) and manner a time, date and place, and du	is stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
			In them M.D	147704	1/2//	09
	₹		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) I Randall	stown no	21133
	Sta Registr		The filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 32. Registrar's Signature for the filed (Mohth, Day, Year) 42. A second for the filed (Mohth, Day, Year) 43. A second f			

P.O. Box 68760, Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 **Physician** 9:19 Рм January 31, Alfred F. Fields /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice- Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 90 Months Days Hours Director 108-03-1644 December 21, 1918 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2**X**☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3310 Gleneagles Drive 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WWI If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. WWII 1 Never Married 2 X Married 1 ☐ Yes 2 K No þ Specify. White Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 Elementary/Secondary (0-12) Communications Engineer Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Fields Rachel Schwartz မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie Fields/Daughter 411 Winding Rose Dr., Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date February 6, 1 XBuria! 2 ☐ Cremation 3 ☐ Removal from State King David Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Falls Church, Virginia 21. Signature Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Obstructive Pulmonary Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him to late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence offs or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □ No 1 □ Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ∐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 K Other (Specify) Hospice 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation ours after death.

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filled in by the fu 1 TYes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and marner stated. 29b. Signa e and title of certifier 29d. Date signed (Month, Day, Year) grenene D0064615 February 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, Maryland 20850 Genevieve Wroblewski, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 30, 2009 8:30 P M Jeanne Whiteman Ferreira 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death N/A 1613 Bank Street Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours SEP 18, 1 □ M 2 X F 201-24-2485 76 1932 Pennsylvania Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1.XYes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1613 Bank Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 🔏 No If Yes, Give Year or Dates: Specify. Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commissary Supervisor Racetrack 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Whiteman Clayre McCartle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5126 Brookwood Rd Baltimore ,MD 21225 Linda J. Reyes/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc 2/2/09 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility

Cremation Society of Maryland, Inc
299 Frederick Rd Baltimore ,MD 21

Physician /Medical Examin

Physician

/Medical

Examiner

**Funeral** 

Director

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'natural", or items 23a

Health and Mental Hygier em 27 Is marked other th

permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau once.

Examiner must be notified at

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

physician and the burial-tran within 24 hours after death To the Funeral Director: completely filled in by the

Division of Vital Records, P.O. Box 68760

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29b. Signature and title of certifi

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MA

shock, or heart failure. List only		or respiratory arrest,	Interval Between Onset and Death
Immediate Cause (Final disease or condition	a head/neck cancer		S YEARS
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Universitying	b Due to (or as a consequence of):		1
Cause (Disease or injury that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of d Month	elivery Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☑	to the cause of death?  Probably 4 ☐ Unknown
		performed? death?	autopsy findings available o completion of cause of es 2 □ No
25. Was case referred to medical examiner?		th (Check only one)	
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4   Nursing H	ome 5 Residence 6 ☐ Other (Sp	necify)
27. Manner of Death 1. → Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		28f. Location (Street and Number or R City or Town, State)	Rural Route Number,
29a. Certifier (Check only 2 Medical Example 1	rysician: To the best of my knowledge, death occurred at the time, date and place miner: On the basis of examination and/or investigation, in my opinion, death occu	e, and due to the cause(s) and manner erred at the time, date and place, and du	as stated. ue to the cause(s)

29d. Date signed (Month, Day, Year)

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State Registrar 2112 Dunda

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician DYC 210 M 0 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) ecation of Death **Examiner** If Under 24 Hrs. Date of Birth Min. Min. April 2, Mors Way 50 01 83000C 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Eirthplace (State or Foreign **Funeral** Year) 947 Months Days 1፟፟፟∭ M 2□ F Kentucky Aprīl 148-44-6846 61 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examination in ust be notified at 1 ☐ Yes 2 🛣 No Director Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 USA 9507 Duffer Way by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Insurance Representative Health Care 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mercedes Barreda John Ford ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. Scott C. Ford, Son 20 Brighton Drive Gaithersburg, Maryland 20887 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/03/09 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licentary Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 🗆 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ 2 🔲 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 No the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29c. License number 29b. Signature and title of certifie noome 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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4 2009

31. Date filed (Month, Day, Year)

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Registrar's Signature

		For State Registrar	State of Mary	_	-	ent of Hea <i>ate of Dea</i>		Mental Hy	giene Reg. No. 20	9	02980
Physicis		1. Decedent's Name (First, Middle, Last)						2. Date of Dea		/ear	3. Time of Death
Physicia /Medic		CHARLES WILLIAM GIBSON	SR.					Februar		POC	9:05/1-M
Examin		4a. Facility Name (If not institution, give s	~ ~ 1	101	4b. C	ity, Town, or Loca	ation of Death		4c. County of	Death	
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the att	Sicie	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at tin		5 Other	c pregnancy (specify)			Mont	n D	ay Year
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To the Hospital or Attendin within 24 hours after death. To the Funeral Director. Aft completely filled in by the fun	Medical	29a. Certifier 1 ✓ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of mer: On the basis of ex	amination and	death occuri or investigat	ed at the time, da ion, in my opinior	ate and place, n, death occur	and due to the red at the time,	cause(s) and man date and place, an	ner as sta d due to tl	ted. he cause(s)
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			for State	State of Marylan		artment of H		nd Mental Hy	giene	
			Registrar  1. Decedent's Name (First, Middle, Last)			illicate of L	Jeain	2. Date of Dea	Reg. No. 2 U	09 02981
	Physici		Althea T. Galgano					Month	Day 28, 200	Year 09 8:00 P M
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
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	item item iner.n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ X Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	S.   13. \	Was Decedent of Hi If Yes, specify Cuba	spanic Origin n, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)		e - American Indian, k, White, etc.
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and	d be fi	Be	17. Father's Name (First, Middle, Last)	1.1						9)
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the "notice event".	2	Earl William Troxe 19a. Informant's Name/Relationship (Typ.		19b. Mailir			rances Tra or Rural Route Numbe		State Zin Code)
	ss 1 and 2 should be of Health and Mente item 27 is marked r other traumatic er		Thomas G. Galgano,					Bowie, MI		state, sip every
altimore,	ss 1 and of Healt item 2 r other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place	e) !	Date	20c. Location - 0	City or Town, State
Ĕ	permit. Pages Department of I Important: If ite any injury or o		Magazian 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		oln Cemet		/4/2009	Brentwo	od, MD
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service License	e	22	. Name and Addres	s of Facility	Robert E.	Evans F	uneral Home
_	<u></u>		allertuno					Road Bowie		
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.		er the mode of dying	g, such as cai	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
- eq	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	PNEUMONI						ONE WEEK
	Examiner			Due to (or as a consequ	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
	ecuted nd transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
90,	icate be executed physician and the burial-transit	Ě	resulting in death) Last	Due to (or as a consequ	uence of):					
98760	icate physi	dical	d.							
×	certiffi nding   Ise as	/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncy				Old Date	o of delivery
Box	death e atten id for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2♣No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	Ectopic pregnancy Other (specify)			Mon	e of delivery nth Day Year
9	t the by the	hys	9 Unknown	9 Unknown						
	w requires that the death certifice is been signed by the attending should be detached for use as	by P	Part II. Other significant conditions conf	tributing to death but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contri	ibute to the cause of death?
o B	equir een s ould		DEMENTIA					1Y	es 2XNo	3 Probably 4 Unknown
ပ္က	B 25 B	Completed						24a. Was a autops	sy pr	Vere autopsy findings available rior to completion of cause of
ᇤ	: The icate ; pag	ပ္ပ						perfor 1 □ Yes	med?   de	eath? □Yes 2□No
<u>=</u>	siclan certif rector	Be	25. Was case referred to medical examiner?	ospital:		t 3 DOA Othe		Death (Check only or		Nursing
ō	Physer this aral di	Certification: To	1 ☐ Yes 2 ₹ No 27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	1 JUDON	426 Nursir	ng Home 5 Resid	ence 6 Othe	er (Specify) Home
DIVISION	nding ath. r: Afte e fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	28c. Injury Work' M 1 □ Y	? ′es 2 □ No		,,	
VIS VIS	r Atte er deg recto by th	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Numbe	er or Rural Route Number,
5	Ital or Irs aft ral Di Iled in	Če		1					,	
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 Medical Examin	cician: To the best of my knowner: On the basis of examinat	wledge, death tion and/or in	n occurred at the time vestigation, in my op	ne, date and p pinion, death o	place, and due to the o occurred at the time, o	cause(s) and mar late and place, a	nner as stated. and due to the cause(s)
	o the	Mec	29b. Signature and title of contifier	and manner stated.		29c. License	number		29d Date signed	(Month, Day, Year)
	- 5 - 0		1.1 and	),,,,						1/09
	7	}	30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type, I	Darland)	6675			-(0)
	/		Tim Capatack	ud, 2001 Med	lical 9	Parkway.	Anna	olis MD	21401	
	Sta		31. Date filed (Month, Da), Year).	32 Registrar's Signat	han	Mark !				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 02982 1. Decedent's Name (Eirst, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2000 <sub>ا</sub> Зi Drend o enius /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Rosedate HOSPITQU 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth \_\_(Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Ę Months Days Hours Min 9 Director lana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified Director 1 ☐ Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ò 1154 6xW00d 23a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must i Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates: 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) celigious minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be ene 2 uanita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son Kd. NXW D. M. Genius a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2-06-09 21. Signature of Funeral Service Licensee 270 Fred HILTON rala conald Grayson F.J. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical ISSIVE gangrenous recrosis, bowel and aboliminal cavity
Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Status post resection of ovarian carrer

Due to (of as a consequence of): be executed burial-tran Records, P.O. Box 68760, physician the IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 ☐ Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death2 performed? 2 No or Vital 2 No Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 DER/Outpatient 3□ DOA Certification: To 1 | Inpatient After this 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3

State Registrar

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

anganath

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Kamakrishn

Franklin Square Drive Ba

			For State	State of Marylar		artment of F		lental Hygi	ene	
F			Registrar  1. Decedent's Name (First, Middle, I	.ast)		Tillicate of t	Dealli	2. Date of Death		3. Time of Death
E	Physicia /Medic		LEV	GOLDENBER	G			Month  JAW . 2	Day Year 31, 2009	12,40AM
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
	**************************************	4	LEVINDALE HEBR 5. Social Security Number 6.	Sex 7. Age (In yrs	. last birthdav)	BALTIM If Under 1 Year	ORE If Under 24 Hrs.	8. Date of Birth	N/A 9. Birt	hplace (State or Foreign
	Funeral Director		212-39-3106	1XM 2□F 89	Yrs.	Months Days	Hours Min.	(Month, Day, 1	Year) Co	untry) (RAINE
	w w		Usual Residence of Decedent  10a, State 10b, County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Maryl I-f sho fied a	tor	MD BAL	TIMORE	BALT	IMORE				1 □Yes 2√□No
	ith the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a nust b	rall	6908 MARSUE DR	IVE, #2A	10 10		1215	asif. Van as Na	USA 14. Race - Ame	ricen Indian
<b>'</b>	fter de r item iiner n	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 1 No		Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, White	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If the m 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 2 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕅 No	Specify:	100	Specify: W	HITE
<u>5</u>	"natu	Completed	15. Decedent's (Specify only highest g	Education grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing 1	6b. Kind of Business/	Industry
75	d withing jiene.  r than the M	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) <b>5+</b>		HYSICIAN	"		MEDICAL	
nd	oe filectal Hyg	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's Name	e (First, Middle, Ma	aiden Surname)	
Maryland	2 should be filed v n and Mental Hygie is marked other t raumatic event, th	2	DAVID	GOLDBER			ESTHER		UNKNOWN	
<u>⊠</u>	and 2 sh ealth and n 27 is r ier traur	1	19a. Informant's Name/Relationship IRINA KUSHNIR			IGH SIDE (			City or Town, State, 2 LS MD 211	
re,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	- i - I		Co. Location - City or	
<u>m</u>	Page ment c ant: If ury or		1 V Buriat 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Cify) A	MUNO CO	T <sup>atory</sup> of other plac )NG.	1 02/0	2/2009 B	ALTIMORE,	MD
Baltimore,	permit. Pages 1 Department of I Important: If ite any injury or ot once,		21. Signature of Funeral Service LTC	nsee		2. Name and Addres	50		ON & BROS.	
			23a. Part1. Enter the disease, or co	mplications that caused the dea			ERSTOWN R	_	ESVILLE, M	Approximate
	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	DEMEN	TIA					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
1		-	Sequentially list conditions, if any, leading to immediate	b	quence of):					
W	outed id ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Ulsaase or injury that initiated events	C.						
8760, X	cate be executed bhysician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a conse	quence of):					
687	ficate the physic sthe to	dical		d						
Box (	eath certific attending p for use as i	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr		□Ectopic pregnancy			23d. Date of del	ivery
П	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of 9□Unknown		Other (specify)			Month	Day Year
, D.O.	w requires that the de been signed by the should be detached		Part II. Other significant conditions	s contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	equires en sign	ed by	ATRIAL F	IBRILLAT 10	N			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 □Unknown
Division or Vital Records,	le law re has bee	Completed	HYPERTER	4510 N	.,			24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
<u>=</u>	iician: The certificate h rector, page							performe	ed? death? No 1 ☐ Yes	
Ž	/siciar s certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ → 6	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpatier	ot 3CLDOA Oth		h (Check only one)	ce 6 □Other (Spec	a/6./\
Ö L	Attending Physician; r death. ector: After this certifice by the funeral director, I	$r \rightarrow r$	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how		эну)
Sio	ttendii leath. ttor: A the fu	catic	2 Accident investigati	on bo		M 1□	Yes 2 □ No			
<u>⊠</u>	after death after death Director: d in by the	Certification:	4 ☐ Homicide determine			eet, ractory, omice		City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Ex	Physician: To the best of my kn	owledge, deat	h occurred at the tir	me, date and place,	and due to the cau	use(s) and manner as	stated.
	the H hin 24 the Fi mplete	Medical	one)	aminer: On the basis of examin and manner stated.	ation and/or in	29c. License				
<b>.</b>	.o ₹ .o ō	_	29b. Signature and title of certifier	1					d. Date signed (Monti	n, ∪ay, rear)
_	F S F O		HD1:04 11	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		/150	6223 -		CALCAL	
	1		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type.	Print)	63327		JAM131,2	Į.
	1			o completed cause of death (Ite	m 23a) (Type.	Print)				Į.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Edward Wesley Gallagher AM 31, January 2009 5:00 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Montgomery Wilson Health Care Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 577-28-7576 Yrs Director 84 February 18, 1924 Washington D. C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov Director 1X Yes 2 No Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Russell Avenue #206 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces: 1 Mayes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 🔀 Married 21215-0036 1 ☐Yes 2 XNo 2 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Tile & Marble of Health and Mental Hygin: If item 27 is marked other or other traumatic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be John Wesley Clark Leona Pearl Stevens ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 Russell Avenue #206, Gaithersburg, Maryland 20877 Elizabeth Mae Gallagher/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If its any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February 5, 4 □ Donation 5 □ Other (Specify) Rockville, Maryland 2009 Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2850 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronicabetuctive pulmona dexerce exaces **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, filled in by the funeral director, page 2 should be 1 🗹 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an Apeitensin. 2 11 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

XI

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

0 4 2009

201 RUSSELL CALTHERSBUR

29d. Date signed (Month, Day, Year)

AUS 6,411

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

09-00817

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 02985

smine Arsia Ha	1	1-For State Control of Pleanth and Certificate of Death	Worna. Trygiewe	Reg. No.	
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	·2. Date o	f Death Day Year	3. Time of Death 2228 hrs
edical Exami	_	Jasmine A. Harris	Janua	ary 27, 2009 4c. County of Deat	
<b>!</b>		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo 3005 Windsor Avenue  Baltimore	ocation of Death .	N/A	
F		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs. 8. Date	of Birth (MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
Funeral Director		214-25-6999 1 M XXF 23 Yrs. Months Days	Hours Min. 111/		ountry) Md
ž.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d d		Md N/A Baltimore			1 X Yes 2 No
Maryfand 28a-f show any d at once.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	untry?
th the Maryland 23a or 28a-f sho notified at once.	嵩		216	USA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryfand tent of Heath and Mehral Hygique.  It is a marked other than "natural", or items 23a or 28a-f sho in thir. If item 27 is marked other than "natural", or items 23a nor 28a-f sho in other tranmatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisparital Status 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, If	anic Origin? ( Specify Yes Mexican, Puerto Rican, etc	or No- c.) 14. Race - Ame White, etc.	rican Indian, Black,
er dea		1 Yes 2\(\bar{\lambda}\) No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2\(\bar{\lambda}\) No	specify:	SpecifyB1a	ck
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72 hor "na al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. If	JO NOT use retired)		
5-0036 ded within 72 Hygiene. Lother than "the Medical.	omp	12 Cashier_	8.Mother's Name (First, Mi	Walmart Walder Surgame	
filed of Hygins of the	O	17. Father's Name (First, Wildere, Edsty	Jestine	Starks	
2121 vuld be fil Mental F marked ic event,	o Be	James Harris  19a. Informant's Name/Relationship (Type, Print)			te, Zip Code)
MD d 2 shorth and n 27 is rumatic		Beverly Carter 3004 Windsor	· Avenue, B	altimore, M	d.21216
Te, I I and Heath Fitem		20a. Method of Disposition 20b. Place of Disposition (Name of ceme crematory or other place)	etery, Date	20c. Location - City of	or Town, State
imore, M Pages I and 2 ment of Health fant: If item 2 or other traus		Mt. Zion Cemete	ry 2/2/20	009 Lansdow	ne,Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 permiter to Heath and Mental Hygiers Important: If tiem 27 is marked other than injury or other tranmatic event, the Medical		21. Signature of Eunéral Service Licens e 22. Name and Address of Estep Bro	of Facility others Fun	eral Servic Baltimore,	e, PA
		23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	w Place.	Baltimore, orvarrest, shock, or heart	Md. 21217
Physician Medical	Sr 3	failure. List only one cause on each line.			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Genshot Wounds (2) of Head and Neck Due to (or as a consequence of):		11 O W A	
		Sequentially list conditions, b			
	miner	if any, leading to immediate Due to (or as a consequence of):			
N'	Exam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	a E	d			-
Ox 68760, eath certificate be executed attending physician and for use as the burial - transit	Medical	UNPENDED AMENDED		23d. Date of delive	200
376( ficate g phy:	M/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy	Month	Day Year
x 68 h certi tendin use a	ician/N	past 12 months?  Pregnant at time of death 5 Other (Specify)			1
Bo ne deat the at	Physi	1 Yes 2 No 9 V Unknown g Unknown	iven in Part I 236	e. Did tobacco use contribute	to the cause of death?
, P.O. B ires that the d signed by the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi		Yes 2 ✔ No 3 P	
ords, F w requires ts been sign should be			24:	a. Was an 24b. Were	autopsy findings available
COFC law re has be	Completed			performed? death	
tal Rectian: The certificate ector, page	S	26 Diago	of Death (Check only one	Yes 2 No 1	Yes 2 No
Vital Rec ysician: The l his certificate l director, page	Be	examiner? Hospital: 4 Inpatient 2 FR/Outnatient 3 DOA	Other Nursing Home		ner: Scene
1 of Vit Jing Physic After this	. To	1 Ves 2 No 28b, Time of Injury 28b, Time of Injury 28c, Injury		escribe how injury occurred	
OD C rnding ath. or: Af	tio	1 Natural 5 Pending FOWND: 1 Y Y Year Y Year Y Y Year Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	res 2 No Subjec	ct shot	
/iSia r Atta rer de rirecto n by t	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office by	or	cation (Street and Number or Town, State)	
Div pital o	Certification:	4 V Homicide determined (Specify) Townhouse / Rowhouse	3005 W	Vindsor Avenue, Baltimore	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	ite and place, and due to t , death occurred at the tim	he cause(s) and manner as s ie, date and place, and due to	tated. the cause(s)
To the within To the comp	Medical	and manner stated.  29b. Signature and title of certifier  29c. License		29d. Date signed (/	
	-	COLARD ALARDONIA O.C.1		January 28, 20	009
V		30. Name and address of person who completed cause of death (Item 23a)			
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21201		
S	tate	31. Date filed (Month, Day, Year)  32. Régistrar's Signature			
Regis	trar	EEB 0 4 2009 Denous 12. 19 ave			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No [ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 2009 Physician seona & /Medical 4a. Facility Name III not institution, give street and number) 5875 Springmount Court 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Eldersburg 8. Date of Birth (Month, Day, Feb 22 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1940 1**√**□M 2□F 68 Michigan 377-40-0436 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is notified at once. Eldersburg Carrol1 MD 1 □Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 21784 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 5875 Springmount Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1963-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 1966 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NSA Elementary/Secondary (0-12) College (1-4or 5+) electrical engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stella Rose Kaminski Casimer Hajduk ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5875 Springmount Ct., Eldersburg, MD 21784 19a. Informant's Name/Relationship (Type. Print) Sarah J. Hajduk (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 2-7-09 Springfield Cemetery 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195, Sykesville, MD 21784 Caronal Margha o who e st 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) META **Physician** STATIC Proston2 monico /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Standarde 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient 28b. Time of Injury . Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Colubra , Mis Registrar's Signate 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a-c. perFH. G888 2/4/09 WS
State of Maryland Department of Health and Mental Hygiene
amend items 8,9,10d,20b per fh g888 2-13-09 vt.

D ITEM#5perFH,G892,6/30/09,WS For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Hughban enneth Jan 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Baltimore, MD If Under 1 Year | If Under 24 Hrs. 4D - 8763 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 6-24-1931 9. Birthplace (State or Foreign **Funeral** 1 **№** M 2 🗆 F Months Days Hours Director 0klahoma Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If I we stead it in it must be notified at any injury or other traumatic event, I'm Medical Examples any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits PA **Funeral Director** Adams 1 ☐ Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 15 17325 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 XYes 2 [] If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ρ Specify: 3 Widowed 4 Divorced hit Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 Elementary/Secondary (0-12) College (1,4or 5+) Pilot Commercial/ Military Airline 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ည Ora Hughbanks Pauline Cherry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Hughbanks 3129 Fairfield Road Gettysburg, Pa. 17325 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
VA. Nat. Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/5/09 Bourne, MA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home Brien D 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ntected 35 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 2 **Z**No 1 ☐Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 MInpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allmon band St. Bultimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 = For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 **Physician** January 2:15 P M Lewis Hartman Robert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Libertytown 11945 Main St. 8. Date of Birth (Month, Day, Mar. 15, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) <sup>Year)</sup> 1954 **Funeral** Days Months Hours 1⊠ M 2□ F Mar. Pennsylvania 54 Director 173-44-2068 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1XYes 2 No Director Libertytown Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21762 11945 Main St. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) building supplies salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norma Wallace Standish Hartman Howard ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Canonsburg, PA 15317 Diane Postrech/ sister 501 Blaine Ave. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/3/2009 Sykesville, MD AllCounty Cremation 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Hartzler Funeral Home athanne Libertytown, MD 21762 11802 Liberty Rd. Part 1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Ulmona, Empolism iday disease or condition resulting in death) /Medical Due to (or as a consequence of): Obstration Polmon Dispuse Examiner xucerbyting Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Obesit 24a. Was an autopsy perform Smo King 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. Dε 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

M

State

Registrar

30 Name and address of person

(Month, Day, Year)

0 4 2009

who completed cause of dea

32. Registrar's Signature

B
68760,
Box
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Records,
r Vital
Division o

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day JAN PO 05 John B. Higinbothom /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis- Long Green Cockeysville Balto. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□F Director 213-20-8829 Usual Residence of Decedent 93 June 28,1915 Maryland with the Maryland 10a. State 10c. Cify, Town or Location 10b. County show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Balto. Md. Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 319 H Limestone Valley Drive 21030 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Y☐Yes 2☐NP937 HYes, Give Year or Dates: 1975 1 Never Married 2 Married 1 ☐ Yes 3 € No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie Math Professor Loyola College or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other treasment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Dulaney C, Higinbothom Elizabeth Cooney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 H Limestone Valley Dr, Cockeysville, Md. 21030 Mary R. Higinbothom Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State 3-26-2009 Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** end nonutos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit ロつへ Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably d ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has To the nospinal - .

Within 24 hours after death.

To the Funeral Director: After this certificate I commistely filled in by the funeral director, pag 2V No Yes Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. May r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide the Hospitai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · MD JAN 29 2009 D0053150 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANTIAGO RO COLUMB'A MO120M Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Russell Hudson Harkins 31 2009 January 7:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Months Days Hours Min. 216-30-6360 74 10/02/1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Maitland Street 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ∐Yes 2 ⊠No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Improvement Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Crue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Benjamin Harkins 19a. Informant's Name/Relationship (Type. Print) Celeste Miller/Wife 327 Maitland Street, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/02/2009 Hanover, Maryland 21. Signature of Funeral Sprvice Licensee 22. Name and Address of Facility Anatomy Gifts Registry

7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Onset and Death

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to fr as a consequence of): wumon

Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No

9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 🔲 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Day

23d Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an 1 □Yes 2 \( \text{No}

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

week

Year

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

1 Impatient 28a. Date of Injury (Month, Day, Year) 5 Pendina investigation

Other: 4 \subseteq Nursing Home 2 ER/Outpatient 3 DOA 28b. Time of

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

1 DNatural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEANS DR

GAO 31. Date filed (Month, State

UPPLIZ CHESA 32. Registrar' Signatu

Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Department of Health a
Important: If item 27 Is
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**Physician** 

/Medical

Examiner

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Physician/Medical

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Baltimore, Maryland 21215-0036

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Hospital or Attending Physician: The law

Director:

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Funeral

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 02992 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month ENOLA ANNABELLE HARRINGTON /Medical JANUARY 27, 2009 2:40 P M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL If Under 1 Year HAVRE DE GRACE HARFORD 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 SF Hours Director 226-38-4443 June 1, 1923 Virginia Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits Director 1X Yes 2 □ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 ral", or items 23a or Examiner must be r 700 W. Bel Air Ave. Funeral Apt. 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or timore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: 3 Widowed 4 Divorced White the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Records Technician Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental 7 Is marked traumatic ဥ Charles Monroe Harrington Letty Esther Dunnayant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a : if item 27 is or other tra Aberdeen, MD 21001 Sharon Cullum / Niece 3133 James Run Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State permit. Page Department of Important: if any injury or once, 4 □ Donation 5 □ Other (Specify) Harford Memorial Gdn 1-30-09 Aberdeen, Maryland 21. Signature of Funeral Service License <sup>22</sup> Name and Address of Facility
McComas Funeral Home, P.A. Kathleen 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the denth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sendomenteshar Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner wite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Month 5 ☐ Other (specify) Year P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Vital 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No npatient 2 ER/Outpatient 3 DOA Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

IRINA

31. Date filed (MorNa, Day Year)

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIKITYAN

SKAYA

500 S. UNION AVE

P.O. Box 68760. Division of Vital Records.

			Please	Type or Prin								_	•	
			For State	State of Ma	arylan		artment of r <i>rtificate of</i>		a wen		giene Reg. No	000	9 1	299:
			Registrar  1. Decedent's Name (First, Middle, I	.ast)			- Intouto of	204		ate of Dea	ath			ne of Death
	Physicia /Medic		Sandry L.	Hilderh	Cunc	1				Month Chucu	Da '2			45 M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of E			/ 4c	. County of De		
كمو	_		Montgomery Gener  5. Social Securify Number   6.			last birthday	Olney If Under 1 Year	If Under 24	Hrs. 8 D	ate of Birt	th	ontgome		ate or Foreigi
	Funeral Director		245-80-7608	1□ M 2ਊ F	60		Months Days		Min. (/	Month, Da ober 1	y, Year)	0.0	Country) ryland	_
7			Usual Residence of Decedent		40- 03									de City Limits
200	shov	ō	10a. State 10b. County			y, Town or L								Yes 2⊠No
tho M	28a-f	rect	Maryland   Montgo	mery	211	ver S <sub>I</sub>	10f. Zip Code				10g. Ci	tizen of What	Country?	
die.	3a or	Funeral Director	14835 New Hamps	hire Avenue	2		20905				Unit	ed Sta	tes	
+	ems 2	iner	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin an, Mexican, F	? (Specify ` Puerto Ricar	Yes or No	-	14. Race - A		ın,
3	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	No		1 □Yes 2X No					Specify: W		
3	atural'	ed b	15. Decedent's	Year or Dates:		16a. Dece	edent's Usual Occup	oation			16b. K	and of Busines	ss/Industry	
j .	an "ng	plet	(Specify only highest	grade completed)  College (1-4or 5	i+)	(Give	kind of work done DO NOT use retire	during most of d)	working					
1 7	ygiene ygiene ier the	Completed	Elementary/Secondary (0-12)			Chir	opractic					iroprac	tor's	Office
	ntal H	Be	17. Father's Name (First, Middle, La Archibald Cleve					18. Mother's	Name (FIR ia Mai			·		
obouid to filed within 70 bours ofter doots with the Mandard	mark matic	ပ္	19a. Informant's Name/Relationship			19b. Mail	ing Address (Street						e, Zip Code)	
20 20	alth ar 27 is 27 is ir trau		James L. Hilder				Woodruff							
5 5	r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		20b. P	Place of Disp emetery, cre	osition (Name of matory or other pla	ce) Fe	Date ebruary	6.	20c. L	ocation - City	or Town, Sta	te
0	ragi ment ant: I		4 □ Donation 5 □ Other (Spe		Metr		n Crematory	r	2009			xandri		ginia
	perfilter rages i afto 2 should be waiting 72 mous after beautiving the way year. Department of Health and Montal Highene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Everging 1 was be realthed at once.		21. Signature of Funeral Service Lic	ensee +	M015	548 R	2 Name and Address obert A. Pun 00 West Mont	ess of Facility phrey Fu	neral H	Iome/R	Rockv	ille, In	c. nd 20850	
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	/Medical xaminer		resulting in death)	Due to (or as	a conseq									
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	iding p	Physician/Medica	IF FEMALE:	23c. If yes, outcome	of pregna	ancv						23d. Date of	delivery	
<b>1 1 2 3 3 4 3 3 4 3</b>	atter d for u	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic pregnan ☐ Other (specify) _	су				Month	Day	Year
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, a	es une igned be de	5	Part II. Other significant condition:	s contributing to death b	ut not res	ulting in the	underlying cause gi	ven in Part I.		300		use contribute		e of death? 4 □ Unknowr
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- iolan	is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆	ER/Outpatie	ent 3 DOA Ot	or.				6 ☐ Other (S	pecify)	
	Affer the	L:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of inju (Month, Da	iry y, Year)	28b. Time Injury	Wo			Describe	how inju	iry occurred	_	
	tor: A	icati	2 Accident investigat 3 Suicide 6 Could no		ury - At be	ome farm s		Yes 2 □ No	_	ocation (	Stroot	nd Number or	Pural Poute	Number
	after of Direct of In by	Certification:	4 ☐ Homicide determine	building, et	c. (Specia	fy)	treet, factory, office			City or To			Tidrai Tidale	rvannoer,
, income	To the note plan of Autonomy Frysholan. The law requires that the beautive timicate be executed within 24 hours affect death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Ex	Physician: To the best caminer: On the basis of	f examina									use(s)
9	vithin 2 of the comple	Medical	29b. Signature and title of certifier	and manner st			29c. Licen	se number			29d. Da	ate signed (Mo	onth, Day, Ye	ear)
	> - 0		Para R	MO			MO	06033.	<u></u>		Ta -	Lastra. 3	0.2	009
1	101		30. Name and address of person wi	no completed cause of c	leath (Iter	m 23a) (Type	, Print)				2 0/ /1	7	-/-	
	Sta	to-	31. Date filed (Month, Day, Year)	32. Registr	Phoniar's Sigha	ture J	= 32	+ 01	ney,	MO	2	2083.	2	
	Registr		30. Name and address of person with the filed (Month, Day, Year)  FEB 0 4 200	9 Strange	ß.	Mari	Ce d							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 3:10 PM M 28, 2009 January Joseph August Hentgen 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Prince Georges County Medical Center Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number Months Days Hours 1 3 M 2 □ F 76 06/10/1932 NY 068-24-9505 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 🛣 No Bowie Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20715-2812 Stonybrook Dr 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 Married Specify: White 1 ☐Yes 2 🗷 No If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced 1952-54 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) <u>Mechanical</u> Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth (Unknown) August Hentgen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2812 Stonybrook Dr. Bowie, MD 20715-Mary I. Hentgen/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Feb 3 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Chesapeake Crematory 22. Name and Address of Facility Signature of Funeral Service Licenses MU0382 Rapp Funeral & Cremation Services Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 🗆 No

**Physician** /Medical Examiner

physician and the burial-transit

attending pl

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funeral director.

After this

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I Director: Aid in by the fu

within 24 hours a

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completely filled filled

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The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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the Medical Exerning

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7 Is marked other

Department of Heal Important: If item 2 any injury or other once. or other

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Pages 1 and 2 should be

altimore, Maryland 21215-0036

Director

Funeral

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Completed

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MD

Examine Physician/Medical Completed by Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

5 Pending

investigation

determined

6 ☐ Could not be

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 🗌 No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

3 Suicide

29a. Certifier

Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 \sum Nursing Home 28c. Injury at Work? 154

1 ☐ Yes 2 ☑ No

5 ☐ Residence 6 ☐ Other (Specify) 28d, Describe how injury occurred home; STruck

Tankey 25, 2009 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hone

28t. Location (Street and Number or Rural Boute Number, City or Town, State) 2017 Start Work 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month Day, Year)

ho completed cause of death (Item 23a) (Type, Print) 30. Name and addr

State

Medical

For State	•	/ Department of H	) 4l-	2000 02005
Registrar	7-10	Certificate of D	Death 2. Date of De	Reg. No 2009 02995
1. Decedent's Name (First, Middle Physician Marilyn H	off-Fletcher		Month Februar	Day Year
/Medical		4b. City, Town, or I		4c. County of Death
Examiner 4a. Facility Name (if not institution 8613 Pilsen		Randall		Baltimore
Funeral 5. Social Security Number	6. Sex 7. Age (In yrs. la.		If Under 24 Hrs. 8. Date of Bit Hours Min. (Month, D.	
Director 577-44-3758	1□M 2ĂF 7	4 Yrs. Months Days	March 3	30,1934 New York
Usual Residence of Decedent  10a, State 10b, County	10c City	Town or Location		10d. Inside City Limits
of State of		Randallstown		1 □ Yes 🌉 □ No
Maryland Bal 10e. Street and Number	timore I	10f. Zip Code		10g. Citizen of What Country?
8613 Pilsner	Road	21133		USA
the state of the s	12 Was Decedent Ever in U.S.		spanic Origin? (Specify Yes or No , Mexican, Puerto Rican, etc.)	
9 light below the state of the	If Yes, Give	1 ☐ Yes 2 ☒ No	Specify:	Specify: White
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Elementary/Secondary (0-12)	College (1-4or 5+)	Bookkeeper		Trucking
17. Father's Name (First, Middle	, Last)		18. Mother's Name (First, Middle	, Maiden Surname)
Maryland State   10b. County   10a. State   10b. County   10a. State   10b. County   10a. State   10b. County   10a. State   10b. County   10a. State   10b. County   10a. State   10b. County   10a. State   10b. County   10b.			Marie Hoe	cschel
19a. Informant's Name/Relation	1	,		per, City or Town, State, Zip Code)
Marilyn Ann C	arroll, Daughter	2715 Lowery Rouce of Disposition (Name of	oad Huntingtown	, Maryland 20639  20c. Location - City or Town, State
20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation	3 ☐ Removal from State cei	metery, crematory`or other place	)	•
Baltimore, Maryland Bal 10e. County Maryland Balt 10e. Street and Number 10e. Street and Nu		co Crematory Ir		Baltimore, Maryland
Thomas Gre		Cremation	Society Of Mary	/land, Inc. more, Maryland 21228
23a, Part 1. Enter the disease, of	r complications that caused the death.	Do not enter the mode of dying	, such as cardiac or respiratory a	arrest, Approximate Interval Between
Immediate Cause (Final	t only one cause on each line.	Verphopathy		Onset and Death
/Medical resulting in death)	Due to (or as a conseque	***		
Examiner Sequentially list conditions.	b			
Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):		
Sequential ist continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):		
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6876( ifficate be inficate be g physicia as the bun ledical	u			
The part of the pa	23c. If yes, outcome of pregnan			23d. Date of delivery
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Division of Vital Records,  I or Attending Physician:  The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a director.  The law requires the after this certification:  The law requires the after this certification:  The law requires the law requires the law requires the law requires the law requirement.  The law requires the law requirement and law requires the law requirement.  The law requirement and law requi	ions contributing to death but not result	ang in the didenying cause give		Yes 2 No 3 Probably 4 Unknown
al Record  The law requir cate has been s page 2 should			24a. Was	
mpl mpl			auto	ppsy prior to completion of cause of death?
The second of th	al I		1 ☐ Yes 26. Place of Death (Check only	2 ☐ Ves 2 ☐ No
Physician: The law and director, page 2 2 Mas case referred to medical examiners.  To Be Complete the law and the	Hospital	R/Outpatient 3 □ DOA Othe		
27. Manner of Death  11 Natural 5 Pendi	28a. Date of Injury	28b. Time of lnjury Work		how injury occurred
Signatural 5 Pendi 11 Attual 5 Pendi 2 Attual 5 Pendi 2 Attual 5 Pendi 2 Pendi 3 Pend	igation	M 1 DY	es 2□No	
DIVISION OF STREET OF STRE	mined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office	28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
or the correction of the corre	ing Physician: To the best of my know	dodgo, doath occurred at the time	and date and place, and due to the	o cause(s) and manner as stated
				, date and place, and due to the cause(s)
	er	29c. License	number	29d. Date signed (Month, Day, Year)
29b. Signature and title of certifi	ÇI.		Į.	4
29b. Signature and title of certifi	Mille MD	D47	683	2/3/29
Kon		23a) (Type, Print)	l	1
Kon	m who completed cause of death (Item	23a) (Type, Print)	l	

		State of Maryl				ental Hygie	ene	
		State Registrar	Cei	rtificate of D			. No 200	
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Kathleen Hackley		T	F	2. Date of Death Month ebruary	2°, 200°	
Examin	er	4a. Facility Name (If not institution, give street and number) 1109 Key Parkway #102		4b. City, Town, or L Frederic			4c. County of Frede	
Funeral Director		5. Social Security Number 219-42-2660 6. Sex 1 M 2 M F 7. Age (In	yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	Hours Min.	3. Date of Birth (Month, Day, ) NOV 19,	(ear.) 1944   1	Birthplace (State or Foreign Country) Maryland
Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. County 10c  Maryland Frederick	. City, Town or Lo	derick				10d. Inside City Limits 1 □ Yes 2∑ No
in the N or 28a-	Director	10e. Street and Number	116	10f. Zip Code		109	g. Citizen of Wha	at Country?
ath wif		1109 Key Parkway #102		21701			USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene.  Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar must be nealined at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Noivorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 Noilf Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 XNo	panic Origin? (Spec , Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)		American Indian, White, etc. White
in 72 hou n "natura nonical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of working	7 16	ib. Kind of Busin	ness/Industry
ad with ygiene ier tha	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Compa	anion			r. Citi	zens
attal Historia	Be	17. Father's Name (First, Middle, Last) Paul L. Kelley		1	8. Mother's Name	First, Middle, Ma Cta Burd	,	
should and Me s mark umath	To	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street an		-		ate, Zip Code)
and 2 fealth a m 27 in		Paul Hackley, Son		Longfellow				
Pages 1 nent of H nt: If ite		I Dunai 2 Ly Cremation 3 Li Removal from State		osition (Name of matory or other place) ematory In	i i			y or Town, State e, Maryland
permit. Departm Importa any inju		21. Signature of Funeral Service Incosee.	C	2. Name and Address remation S			nd, Inc	land 21228
		23a. Part1. Enter the disease, or complications that caused the caused the caused the cause or each line.						Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a condition)		roxe	Cardia	ascula	r dise	Onset and Death
Examiner	ji.							
ecuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
te be executed yslcian and e burial-transit	cal	resulting in death) Last  Due to (or as a cond	sequence of):					
ertificat ing phy	Medi	IF FEMALE:						
The law requires that the death certificate ete has been signed by the attending phys page 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date o Month	
is that the	by Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribu	ite to the cause of death?
w requires that the de been signed by the should be detached		Hypertension				1 ☐ Yes		☐ Probably 4☐ Unknown
n: The law licete has t r, page 2 s	Completed					24a. Was an autopsy performe 1 □ Yes 2 ¶	d? prio	re autopsy findings available or to completion of cause of th?  Yes 2 □ No
ysicial is certi directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	Othor	26. Place of Death ( 4 ☐ Nursing Hom		ce 6 □Other	(Specify)
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificete he completely filled in by the funeral director, page	Certification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year  2 Accident investigation	28b. Time of Injury	Work?		3d. Describe how		(3,000)
al or Att after de I Direct d in by t	ertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - / building, etc. (Sp.		eet, factory, office	28	Bf. Location (Stree City or Town, S	et and Number ( State)	or Rural Route Number,
ne Hospita 1 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	knowledge, deatl mination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cau d at the time, date	se(s) and mann and place, and	er as stated. I due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License				Month, Day, Year)
,		30. Name and address of person who completed cause of death	(Item 23a) /Time		1058		2-3-0	7
\		Dr. Gene Ash MD 10200 Copperm	ine Road	Woodsbord	, Marylan	nd 21789		
Sta Registr		31. Date filed (Month, Day, Year)  September 1. Date filed (Month, Day, Year)  33. Registrar's S	ignature	ukel				

BALTIMORE MARYLAND GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F 230-22-5422 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If I will feat any Injury or other traumatic event, I'm Widton Evantiant into the motified at any price. 10c. City, Town or Location 10a. State 10b. County Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 21216 21215 2202 BRADDISH AVE. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -12--0-POSTAL SERVICE 17. Father's Name (First, Middle, Last) Be MORRIS HAYES JR. MARIE TUCKER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PHYLLIS HAYES (DAUGHTER) 2202 BRADDISH AVE. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 X Removal from State 5 ☐ Other (Specify) MT. POOLE BAPT CHURCH 2-7-2009 4 ☐ Donation HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Service Licensed ONATHAN Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 ₹No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation

1. Decedent's Name (First, Middle, Last)

FLOYD ROOSEVELT HAYES

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

2. Date of Death JANUARY 30, 2009 3:45p M 4c. County of Death Year 1926 9. Birthplace (State or Foreign Country) N/A 8. Date of Birth (Month, Day, 8-31-1 10d. Inside City Limits 1X Yes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 20c. Location - City or Town, State FORD, VIRGINIA 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Onset and Death hronic 23d, Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 2 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 21228

Reg. No. 2009

State Registrar

n 24 hours after death le Funeral Director: / bletely filled in by the f

within 2

Medical

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 ☐ Could not be

GEIPE

FEBO 4 2009

CATONSVILLE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ROAD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

02055006

MA

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8&10f Per FH C888 / 2/06/09 TH State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

			1 - For State Registrar	State of Mary		artment of rtificate of			giene () () () () () () () () ()	02998		
	Physici		Decedent's Name (First, Middle, Lass     Helen Jeanette				<u>.</u>	2. Date of De Month	Day Yes	3. Time of Death		
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  ARIPH (AR)							4c. County of Death  AAR FOR		
	Funeral Director		5. Social Security Number 6. Si 212–28–4668  Usual Residence of Decedent	□ M 2X F 7. Age (In 7.	yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days		in. 8. Date of Bir (Month, Da 06/06	<sup>th</sup> y, Year) 9.1 /1929 M	Birthplace (State or Foreign Country) aryland		
	Maryland f ehow	tor	10a. State 10b. County  MD Harford	ļ	. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2/€ No		
	or 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?		
	eth wi		903 D Swallow Cr			21040			U.S.A.			
036	be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other then "neturel", or iteme 23a or 28e-f ehow event, I're Medical Examinar mast Le notified at	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ※ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	oan, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	Black, W	merican Indian, hite, etc. Nhite		
215-0	thin 72 ho e. en "netur Medical	Completed	15. Decedent's Ed (Specify only highest graves) Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. Kind of Busine	ss/Industry		
121	it Hygien other th		8 17. Father's Name (First, Middle, Last)		Nur	sing Ass	1	Name (First, Middle,	·	re Industry		
Maryland 21215-0036	should be find Mental Find Mental Financed of	To Be	Harry Wesley Car		401 14 10		jeane	ette Fairl	banks			
	allth a		19a. Informant's Name/Relationship (7)  Brenda Smith (6)	daughter)					er, City or Town, State e, Marylan			
Baltimore,	m O		20a. Method of Disposition  1 Burial 2 Cremation 3	20	b. Place of Dispo			Date	20c. Location - City			
Itim	t. Pa ntmen rtant:		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen:	) M					Baltimore,	Maryland al Home, P.A.		
Ba	Depermine Depe		1 E. D. X	assaln	1	1750 Bel	air Road	l - Kings	ville, Mar	yland 21087		
ı	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Diahetus	Melli	M'S	ing, such as card	nac or respiratory a	nest,	Approximate Interval Between Onset and Death		
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Pue to (or as a con	sequence of):	Rigar	heel					
30	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. My tym	sequence of):							
68760,	icate be e physicier s the buri	dicai	Ĺ	· MpnAm	irs							
. Box	that the death certific ed by the ettending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date of a Month	delivery Day Year		
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.			to the cause of death?  Probably 4 Unknown		
Division of Vital Record	e la	Completed		[				24a. Was autop perio 1 \( \text{Yes}	an 24b. Were prior to death 1 Y			
Zits	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	200	eath (Check only o				
ō	Phys er this erel dir	٦: T	27. Manny of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	I 3L DUA	4 Nursing		dence 6 Other (S	pecify)		
sion	ttending I death. ctor; Alter t the funer	atio	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Yea	r) Injury		rk? ]Yes 2 □No					
É	in the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or Tou				
	To the Hospital within 24 hours a To the Funerel Completely filled	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred at the treestigation, in my	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier  MSWGIM	M.h		29c. Licens	se number		29d. Date signed (Mo	Of Osy, Year)		
	3		30. Name and address of person who c	ompleted cause of death (	Item 23a) (Type,	Print)	int	2/ 57	78			
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	barks	y. v1		V			

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, \*

			Pleas	e Type or Pri						-		_	ble.	
		State of Maryland / Department of Health and I  State of Maryland / Department of Health and I  Certificate of Death						Mental H	Reg. No. 2009 02					
Division		Decedent's Name (First, Middle, Last)							2. Date of D		Day	Year	3. Time of Death	
Physicia /Medic	al .	Grace M.						<u> </u>		02-03-	-200	9		335 A <sup>M</sup>
Examin	er			give street and number)				4b. City, Town, or Overle		ath	4	c. County	of Death time	
Funeral		5. Social Security N	iner 6	. Sex 7. Ag	je (In yrs.	ast birth	day) _	If Under 1 Year	If Under 24 H	rs. 8. Date of B	irth		9. Birth	place (State or Foreign
Director		215-36-90	96	1□M 2X F	70	Y	rs.	Months Days	Hours M	in. (Month, L 10-14-			Cou	MD
w w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	v. Town	or Loca	ation					T	10d. Inside City Limits
Maryla	Ď	MD	, , , , , , , , , , , , , , , , , , , ,		Ra	ltim	ore						1 X Yes 2 □ No	
r 28a	irec	10e. Street and Nur	nber		10f. Zip Code						10g. (	Citizen of V	Vhat Cou	ntry?
th with	Funeral Director	6116 Bel	air Rd		21:			.206			USA			
tems	nue	11. Marital Status	_	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	Ever in U.	S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-		e - Ameri k, White,	can Indian, etc.
rs afte	by F	1 ☐ Never Marri 3 🛮 Widowed	ied 2 Marrie	lf Yes 2 2∆1 If Yes, Give Year or Dates:	No		1 [	□Yes 2 <b>X</b> No	Specify:			Specify	. Wh:	ite
2 hou	ted		15. Decedent's	Education grade completed)		16a. [	Decede	ent's Usual Occup	ation	vorkina	16b.	Kind of Bu	usiness/Ir	ndustry
ithin 7 ne. han "r	Completed	Elementary/Seco		College (1-4or	5+)			ind of work done O NOT use retired ker	d) "1001 01 1	romang		wn Ho	mo	
filed w Hygie ther ti	ပ္ပိ	17. Father's Name		ist)		11011	ema	.KeI	18. Mother's N	lame (First, Middl				
ld be lental ked o ic eve	To Be	Lawrence							G1adys	P. Surb	aug	h		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It a Profical Exercitor must be rottined at once.		19a. Informant's Na Darlene		(Type. Print) (Daughter)						Rural Route Num Abingdor				p Code)
of Hear	1	20a. Method of Dis		☐Removal from State	20b. F	Place of E emetery	Disposi crema	ition (Name of atory or other place	ce)	Date	20c.	Location -	City or T	own, State
Page ment ant: If			5 ☐Other (Spe				w C	rematory	02	-05-2009	Ва	ltimo	re,	MD
Depart Import any In		21. Signature of Fu	ineral Servi <del>ce Li</del>	censee				Name and Addre		Schimunek	Fu	nera1	Hom	e of BelAir
		23a. Part 1. Enter t	e disease, or o	omplications that cause	d the deat	h. Do no				nail Rd F diac or respiratory		Alr,	<u>MD_2</u>	Approximate
Physician		shock, or hea Immediate Cause disease or condition	(Final	nly one cause on each I	ne.	lm	$\Omega$	nia						Interval Between Onset and Death
/Medical Examiner		resulting in death)	1	Due to (or as	a conseq	uence of	·):	uu_						
	-G	Sequentially list conif any, leading to im	nditions,	b Due to (or as	a conseq	uence of	);							
e exec ian an ırial-tr	Exa	resulting in death)		Due to (or as	a conseq	uence of	·):							
icate be physici s the bu	dica			d										
eath certific attending p for use as	n/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome								23d. Da	te of deliv	/ery
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medica	in the past 12 1 ☐ Yes 2 <b>\</b> 9 ☐ Unknown	months?	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown				Ectopic pregnand Other (specify) _	ey .			Mo	onth	Day Year
signed by		Part II. Other signit	ficant condition	s contributing to death t	out not res	ulting in	the und	derlying cause giv	en in Part I.	23e. Dio	l tobacc	o use cont	ribute to	the cause of death?
w require been signature should b	ted t	COPD	, 47	N						_ 1□	] Yes	2 □ No	3∏ Pro	bably Unknown
law n has be	Completed by									– 24a. Wa	opsy		prior to co	opsy findings available ompletion of cause of
siclan: The law certificate has b irector, page 2 s										1 □ Yes			death? 1 □ Yes	2V No
siclar s certification	) Be	25. Was case referexaminer?		Hospital:	ient 2 🗆	ER/Outr	nationt	3 □ DOA Oth	er.	Death <i>(Check</i> o <i>nly</i> g Home 5 ☐ Re		6 🗆 Oth	or (Cana	(4.3)
ding Phys h. After this c funeral dir	n: To	27. Marmer of Deat	th _	28a. Date of Inj	ury	28b. Ti		28c. Inju		28d. Describe				1197
eath. or: Af the fur	catio	M Natural 2	5 ☐ Pending investiga 6 ☐ Could no	tion				M 1 □	Yes 2 □No					
after d Direct Jin by	Certification: To	4 Homicide	determin	ed 28e. Place of In building, e	jury - At ho tc. <i>(Specil</i>	ome, farr fy)	n, stree	et, factory, office		28f. Location City or T			er or Rui	al Route Number,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	1 Certifying 2 Medical E	Physiclan: To the best xaminer: On the basis and manner s	of examina	wledge, ation and	death l/or inve	occurred at the ti estigation, in my	me, date and plopinion, death o	ace, and due to the courred at the time	ne cause e, date a	e(s) and m and place,	anner as and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and	I title of certifier					29c. Licens			29d. l	Date signe	d (Month	, Day, Year)
		Ma	MA					64	493		Do	2-03	-20	109
3	4	30. Name and add	ress of person w	ho completed cause of	N-	Elv	ype, P	vint) Stee	et Bo	utimo	10	N	12 2	11201
Sta Registr		31 Date filed (Mon	nth, Day, Year)	32. Regist	rar's Signa	iture	of the second	de s	3					
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day VIAN Senkins 9:01 AM 03 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore MEMORIAL (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1 □ M 2 1 F MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑Yes 2 ☐ No imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1606 050 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ■ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) eemtress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JenKENS MARIAN 19a. Informant's Name/Relationship (Type. Print) Paughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michel Pikeville, md tead 20a. Method of Disposition Date 1 Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Puneral Pervice Licer Willert's metkapolitano Broadway 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin disease or condition resulting in death) Strepto coccus SEPSIS obesi Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Metabalic 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Completed by Funeral

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event

Baltimore, Maryland 21215-0036

Physician/Medical

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and Hospital or Attending Physician: The law requires that the death certificate be exect signed by the attending physician I be detached for use as the buria

Division of Vital Records, P.O. Box 68760,

within 24 hours after deat To the Funeral Director;

Comple			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No    24b. Were autopsy findings availabe prior to completion of cause of death?  1 ☐ Yes 2 ☐ No    24c. Was an autopsy findings availabe prior to completion of cause of death?
e n	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only one)
0	1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Montin, Day, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Certific	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
dical	29a. Certifier 1 ✓ Certifying Pt (Check only one) 2 ☐ Medical Exam	nysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alcheikh Memorra

31. Date filed (Month, Day, Year) Registrar's Signature FER 0 4 2009

State Registrar